3 How far have we come in implementing integrated mental health, skills and work policies?

This chapter presents the key findings on the implementation of the OECD Recommendation on Integrated Mental Health, Skills, and Work Policy five years after its adoption. While countries are increasingly focusing on integrated policies at the strategy level and awareness-raising efforts are continuing, this is often yet to translate into integrated and well-connected practices at the working level. Progress has also been uneven across the thematic areas, with innovative and integrated practices increasingly seen in youth policies, whereas integrated practices remain rare especially in employment services and the welfare system.

Progress towards integrated mental health, skills and work policies is highly uneven across different policy areas

Five years on from the adoption of the *OECD Recommendation on Integrated Mental Health, Skills and Work Policy*, the importance of a whole-of-government approach to mental health policy is widely accepted across OECD countries. Almost three-quarters of countries responding to the Mental Health Benchmarking Policy Questionnaire (OECD, 2020[1]) in 2020 reported having in place national programmes or strategies for integrated and cross-governmental approaches to mental health governance. OECD countries also fully recognise that tackling stigma on mental health is a requirement of integrated mental health policy.

Box 3.1. Assessing the implementation of the OECD Recommendation on Integrated Mental Health, Skills and Work Policy between 2015 and 2020

The Recommendation instructs the Employment, Labour and Social Affairs Committee and the Health Committee of the OECD to "monitor progress and policy development, including through the use of relevant indicators… no later than five years following its adoption." These two committees include representatives from all OECD countries and oversee OECD work on labour market, social and health policies. To support the two committees on fulfilling this instruction, the OECD Secretariat prepared a draft report to assess progress and policy developments (the "2021 Implementation Report") between 2015 and 2020. The Implementation Report was approved by the two committees in April 2021. It was then noted and declassified by the OECD Council, and made available to the public in October 2021.

This current chapter presents a reader-friendly version of key findings of the implementation report on policy developments between 2015 and 2020. The findings are primarily based on responses from 30 OECD countries to a questionnaire sent by the OECD Secretariat in August 2019 to understand policy developments in each country over this five-year period, supplemented by information provided by countries through their responses to the 2020 Mental Health Benchmarking Policy Questionnaire. Unless otherwise specified, the information in this chapter come from these two sources. The content of this chapter has benefitted from the reviews and written comments from 17 OECD countries at various stages of its development. The main findings have also been discussed in meetings of the Employment, Labour and Social Affairs Committee, the Health Committee, and the Education Policy Committee, which oversees the work of the OECD on education policy.

Note: of the 30 countries providing responses, two countries were accession candidate countries, namely Colombia and Costa Rica. Colombia officially became the 37th member of the OECD in April 2020, and Costa Rica became the 38th member in May 2021. As both countries became Adherents to the Recommendation upon becoming OECD members, they are included in the analysis in this publication.
Source: OECD (2021[2]) Implementation Report of the Recommendation of the Council on Integrated Mental Health, Skills and Work Policy; OECD (2020[1]), OECD Mental Health Performance Benchmark Data and Policy Questionnaire.

Yet translating these intentions into integrated practices at the working level remains a major challenge, with significant differences in the extent of progress between countries and in different policy areas. While there is significant recognition in youth policies for an integrated approach that responds to mental health and its impact on education and employment, and new integrated practices have been widespread across OECD countries, there remain few initiatives in welfare systems that systematically link and integrate mental health and employment services.

- **Health care systems** are increasingly prioritising mental health and there is an increased recognition of integrating mental health care treatment with youth, workplace and employment interventions. Such efforts still seem to be often at the strategy level, however, and examples of

working-level implementation of integrated mental health, skills and work policy in the health care system are still relatively limited owing to structural barriers to integration.

- **Youth support and education systems** have implemented many innovative initiatives since the adoption of the Recommendation, and many of these initiatives focus on providing mental health supported that is integrated with education and employment support. The significant progress seen across OECD countries also reflects the prioritisation of strengthening child and adolescent mental health services and policies to promote young people's mental health in recent years.
- **Workplace policies** also reflect the need for a more integrated approach that addresses workers' mental health and employment challenges concurrently. Despite this, workplace policies implemented by OECD countries remain largely focused on psychosocial risk prevention, often overlooking the importance of other aspects of mental health in the workplace. Mental health support for individuals on sick leave remains inadequate – this may be the result of lack of clarity over where responsibility for mental health support switches from the employer to the authorities managing employment services and social protection.
- **Welfare systems** – employment services and social benefits – are lagging significantly behind in most OECD countries in developing and implementing integrated mental health, skills and work policy, especially for individuals with mild-to-moderate mental health conditions. Such conditions are highly prevalent among benefit recipients and employment service users. In isolated cases of integrated services for individuals with mild-to-moderate mental health conditions, the initiative tends to come from the health system. It is unclear what is stopping governments from investments in scaling up integrated health and employment services that have shown good results.

Progress is also uneven across the key dimensions of an integrated approach

Structural barriers to implementing a whole-of-government approach and the continued shortage of finances dedicated to mental health also continue to hamper efforts to develop more integrated support and intervention for people experiencing mental health issues. These are among the major obstacles that continue to prevent OECD countries from ensuring provision of truly integrated health, education and employment interventions (the "what"). By comparison, OECD countries have made substantial progress in equipping front-line stakeholders such as teachers, managers, caseworkers or general practitioners with better mental health competence and increasingly also with knowledge on the links between mental health, education and employment (the "who"). OECD countries are also shifting to prevention, promotion, and early identification of individuals experiencing mental health issues, although timely intervention is often still confined to silos and need to become more integrated (the "when").

Such uneven progress across the "who", the "when" and the "what" can be problematic as effective and timely support for individuals experiencing mental health issues is reliant on success on each of the three dimensions. For instance, some OECD countries have made progress in reducing waiting times for mental health treatment and providing more timely treatment (thus seeking to address "when"). Yet further progress is possible if treatment is provided together with employment support in cases where mental health issues have contributed to job loss (thus addressing the "what"). Insofar, even slow progress in integrated, timely and appropriate polices and services – linking the "who", "when" and "what" – may deliver better outcomes for persons experiencing mental health issues and thus also for the society-at-large than uneven yet fast progress in specific elements of integrated mental health policy.

Countries are in different stages in the development of integrated mental health, skills and work policies

An assessment of the implementation of the Recommendation makes clear that OECD countries are in very different stages in the development towards integrated mental health, skills and work policy, and even within countries, policy development is often uneven, with more progress being seen in some policy areas (e.g. education and youth) than others (e.g. employment services and welfare systems). Countries tend to fall under one of the following four stages.

- **Stage one: Developing the right rhetoric.** Countries in this stage often lack a national mental health plan, and even where they do, show little to no focus on developing integrated mental health, skills and employment services. These countries tend to have only recently started focusing on mental health policy, and stigma against individuals with mental health conditions is highly prevalent. Policy priorities in this stage tend to focus on expanding capacity for community-based mental health services and in some countries, raising public awareness of mental health.
- **Stage two: Building the foundations for integrated mental health, skills and work policy.** Countries in this stage have national mental health plans that emphasise the need for integrated mental health, skills and employment services, but there remain only trials and small-scale policies that provide these integrated services within and outside the health system. Policy priorities in this stage tend to remain focused on the expansion of community-based mental health services and awareness raising, while in parallel, placing emphasis on building the foundations for integrated mental health, skills and work policy.
- **Stage three: Shifting from trials to a scaled-up integrated approach.** Countries in this stage have established mental health plans and strategies for integrated mental health, skills and employment service delivery. In this stage, effective and innovative trials and small-scale policies to provide integrated services are widespread, but such trials are often not scaled-up. Countries in this stage tend to have reached a baseline level of public awareness and primarily rely on community mental health services to support individuals with mental health conditions. Policy priorities in this stage differ somewhat across countries, but those making the most progress place significant emphasis on scaling up integrated policies and service delivery and addressing structural challenges that prevent inter-agency co-ordination.
- **Stage four: Integrated mental health, skills and work plans in practice.** Countries in this stage are executing well-developed integrated mental health, skills and work plans through large-scale evidence-based treatments and interventions – although progress tends to be uneven across the thematic areas. In this stage, mental health performance indicators that go beyond the health care system – such as employment targets – are not only being increasingly developed, but are also included within national mental health plans. Countries in this stage are at the forefront of implementing integrated mental health, skills and work policy among OECD countries. Policy priorities at this stage focus on further extending the availability of integrated mental health, skills and employment services and filling in specific gaps that exist in support for individuals experiencing mental health conditions.

The lack of complete and fully comparable information and data on developments in integrated mental health policy makes it difficult to assign countries to specific stages. It can nonetheless be said that a majority of OECD countries fall around stage two or three, with the remaining countries found in roughly equal shares in either stage one or stage four. The uneven progress across thematic areas also means that while a large number of countries are in stage three or beyond in youth support systems, very few are at a comparable stage for welfare systems.

Strategies reflect the need for a mental-health-in-all-policies approach

Over the past five years, OECD countries have increasingly come to accept the importance of an integrated mental health, skills, and work policy, as shown by the existence of national plans and strategies that emphasise a whole-of-government approach to mental health. In the Mental Health Benchmarking Policy Questionnaire sent to OECD countries in January 2020, almost three-quarters reported having national programmes or strategies for integrated and cross-governmental approaches to mental health governance, and almost all countries reported having mental health strategies or work programmes in ministries other than the Ministry of Health.

Yet much like with the implementation of practices at the working level, the extent to which the thematic areas – health systems, youth policies, workplace policies, and welfare systems – are covered in national mental health plans and strategies varies widely across OECD countries. Most of these plans remain largely centred around the health system, with countries often designing strategies specifically for children and young people. By comparison, considerations for workplace policies and welfare systems are only occasionally integrated, or left at the fringes of national mental health plans. This means that significant areas of government policy, which could make a difference to mental health, are not included in mental health policy, and while there is an emphasis on integration, OECD countries continue to see mental health as first and foremost an issue for the health system.

An increasing emphasis on integration in national mental health plans and strategies

The past five years have seen a significant number of OECD countries adding youth, employment and social protection dimensions of mental health in their national strategies or plans for the first time. While many of these countries have not necessarily set clear youth, employment or social protection targets, their latest plans demonstrate a new commitment to a cross-governmental approach, which represents progress from past plans focusing almost entirely on the health system.

An example of an OECD country that has made significant progress in its latest national mental health plan is Colombia (see Box 3.3). After first recognising the importance of addressing the socio-economic dimensions of mental health in 2013, the country put in place a new National Mental Health Policy in 2018, which calls for policies to ensure the inclusion of people with mental health issues in educational, social and workplace environments. The accompanying strategy to promote this plan, published in 2020, sets out clear areas of responsibility for a wide range of government ministries. In Poland, the National Mental Health Protection Programme for 2017 to 2022 calls for implementation of mental health policy by a range of ministries – health, social security, family, education, labour and beyond – and includes a specific qualitative objective of improving employment support provided to jobseekers with mental health conditions. These recent examples show that regardless of where an OECD country is at in its mental health reform process, they can put in place national plans and strategies on mental health that emphasise the importance of an integrated mental health, skills and work policy. For OECD countries that fall in this category, the challenge remains to translate these strategies into action, and furthermore, to develop clear measures and objectives to assess improvements in the integration of the education, employment and welfare outcomes in mental health policy.

A few countries have operationalised education, employment and welfare outcomes within mental health plans. In England (United Kingdom), the government accepted all the recommendations from the 2016 Five Year Forward View for Mental Health by the Independent Mental Health Taskforce to the NHS in England, which explicitly called for better integration of employment and the social protection system in mental health policy. One of the targets is to increase the number of people with mental health conditions supported in finding or staying in work by 29 000 each year through to 2020/2021 by expanding both the Increasing Access to Psychological Therapies initiative (IAPT) and Individual Placement and Support (IPS) programmes (Independent Mental Health Taskforce to the NHS in England, 2016[3]). In the

Czech Republic, the most recent mental health plan from 2020 includes a goal to reduce unemployment among individuals experiencing severe mental health conditions by 5% by 2024.

Young people are often a target group in integrated mental health strategies

The development of new mental health plans specifically for children and youth indicates the importance given to this age group among OECD countries. In the OECD Mental Health Benchmarking Policy Questionnaire, 17 out of 27 responding countries reported having specific national or sub-national mental health strategies for children and/or young people (OECD, 2021[4]). This represents a stark change over the past 20 years, as no country had such a plan at the beginning of this century (Shatkin and Belfer, 2004[5]). While approaches differ across the OECD, many noteworthy strategies and plans on child and youth mental health have been put into place recently that may offer insights for other countries seeking to prioritise this policy area.

In both Ireland and the United Kingdom, for example, taskforces have recently delivered reports on child and youth mental health that have become de facto national mental health plans. In England (United Kingdom), the taskforce prepared the publication, *Future in Mind in 2015*, which set out clear recommendations for the government to pursue to address shortcomings on child and youth mental health. The key themes, which include early intervention, low-threshold services and developing the workforce, are all closely aligned with the Recommendation. Future in Mind has since evolved into a national initiative of the Ministry of Health and NHS England. A taskforce was also recently commissioned in Scotland (United Kingdom), and the recommendations from the taskforce were published in 2019. Similarly, in Ireland, the recommendations from the taskforce report in 2017 recognised the importance of strengthening mental health services in both schools and higher education institutions, including the transition from school to university, which the Recommendation recognises as a key area for improvements in mental health policy.

While France and New Zealand have taken a different approach by placing mental health within the broader framework of well-being, they have also clearly prioritised the mental health of children and young people. In France, the President requested the development of a *Plan d'action en faveur du bien être et de la santé des jeunes* (or Action plan for youth well-being and health). The action plan, launched in 2016, includes concrete actions to promote earlier identification and timelier treatment for individuals with mental health conditions through strengthening psychological support available in higher education institutions, as called for by the Recommendation. New Zealand launched its first-ever child and youth well-being strategy in 2019 led by the Department of the Prime Minister and Cabinet, which identifies improving support for children and young people to promote mental well-being as one of three priority areas. In both countries, the initiative did not come from the health system, but from the President and the Department of the Prime Minister and Cabinet, indicating that the prioritisation of child and youth mental health is increasingly coming from central government figures.

In Canada, where mental health strategy is largely set by provinces and territories, innovative child and youth mental health plans have also recently been developed. The Framework for the Delivery of Integrated Services for Children in New Brunswick 2015, for example, sets out a vision for more integrated mental health services and guiding principles on implementing such practices, which closely resembles the Recommendation. In Australia, the National Mental Health Commission developed the country's first-ever National Children's Mental Health and Wellbeing Strategy for children from birth to 12 years of age (Australian Government, 2021[6]). The government announced the development of the strategy in 2019, which was developed over the course of two years, and then released in October 2021.

Structural challenges remain to translate national mental health plans into practice

Despite the widespread rhetoric and intention for a more integrated mental health, skills and work policy in national mental health plans, successful implementation of such integration remains the exception, not the norm. This partly reflects structural barriers that make working-level collaboration between multiple ministries, agencies and departments within governments costly or difficult to implement. This is a particularly significant obstacle when addressing mental ill-health, as the topic does not easily fall into the existing organisational structure of governments and civil society.

OECD countries are aware of structural challenges and the difficulties they impose on implementing integrated mental health, skills and work policy. For example, Ireland organised three pathfinder projects to experiment and help develop new models for more effective whole-of-government work as part of its Civil Service Renewal Plan. One of the pathfinder projects was specifically on youth mental health policy, the findings of which were released in 2017. Ireland is currently in the process of establishing a Youth Mental Health Pathfinder Team to put these findings into practice.

Similar measures have been taken in Sweden, where in 2015, the government commissioned a national co-ordinator to look into the state of mental health policy and make structural recommendations to allow for better co-ordination of mental health policy at various levels, including for example, between government ministries and agencies, municipalities and the health sector. On the basis of the findings of the inquiry of the national co-ordinator (Swedish Ministry of Health and Social Affairs, 2019[7]), 24 government agencies have been asked to jointly develop a new strategy for mental health and suicide prevention policy, which will be presented in 2023.

In the United Kingdom, a Work and Health Unit (WHU) was set up in 2015 as a joint unit of the Department for Work and Pensions and Department of Health and Social Care, with the aim of taking a whole-of-systems approach to health, including specific measures related to mental health. To address the siloes that limit integrated approaches to health and work policies, the WHU prepared a report in 2019 setting out proposals on how the government and employers can better support workers managing health conditions, including mental health issues, at work (HM Government, 2019[8]). The proposals were then made available online in a public consultation, and the findings from this will be released shortly.

There also remains a shortage of investment seen in mental health policies across OECD countries despite the increasing political will to address mental health issues. While methodological challenges make comparison across countries difficult, based on responses to the OECD Mental Health Benchmarking Policy Questionnaire, among countries for which data is available, mental health spending as a proportion of total health spending largely remained unchanged between 2009 and 2019 (OECD, 2021[4]).[1]

Given the continued shortage of investment in mental health and barriers to integrating mental health policies, financial incentives can play a key role in encouraging stakeholders to develop more coherent and integrated mental health services. As a starting point to create such financial incentives, it is essential that budgets are also allocated to mental health in ministries other than the Ministry of Health. Responses to the OECD Mental Health Benchmarking Policy Questionnaire indicate that most countries do not have dedicated mental health budgets for ministries other than the Ministry of Health and many countries had difficulty in identifying whether a dedicated mental health budget existed (OECD, 2021[4]). This is an area where OECD countries can make significant progress over the coming years.

New Zealand has developed a novel approach to creating financial incentives for more integrated mental health services through its Well-being Budget. Instead of basing the budget on initiatives developed by ministries and agencies, it is based on priority areas to promote well-being that are first identified in Cabinet (New Zealand Treasury, 2019[9]). The first budget developed through this method in 2019 resulted in dedicated and record levels of funding being allocated to mental health. While mental health may not have been the top priority for any specific agency or ministry, it was identified as one of five key priority areas where there are the greatest opportunities to improve the well-being and lives of New Zealanders.

Box 3.2. Policy Developments in Mental Health in Colombia, 1998-2020

1998: the first *National Policy of Mental Health* is adopted under the General Health Social Security System. The policy encompasses prevention, screen and mental health services, but there is difficulty executing the plan due to reasons including a lack of funding.

2005 and 2007: the Ministry of Social Protection publishes the *Guidelines of Policy of Mental Health in Colombia* in 2005 and the *National Policy of the Field of Mental Health* in 2007. These look to build upon the 1998 law but are only guidelines on how to develop mental health policy.

2007: the ***2007-2010 National Public Health Plan*** identifies improving mental health as a priority issue, but the focus remains largely on the health system. The most notable target in the plan is to reduce the consumption of psychoactive substances in all territorial entities.

2013: ***Law 1 616 on Mental Health*** modifies and updates the *National Policy of Mental Health* of 1998. The law outlines the rights of people with respect to their mental health, and sets out priorities including prevention of mental illness, promotion of mental health and an integrated approach to mental health. In this law, the term integrated refers largely to integration within the health system. Shades of a more integrated approach to mental health are becoming apparent, with the law including a specific Article on the promotion of mental health in the workplace. The Law also calls for the development of a National Mental Health Council, which meets for the first time in 2016.

2013: Colombia adopts the ***2012-2021 Ten-Year Public Health Plan*** in March. This plan makes mental health a priority area and adopts an approach that recognises that socio-economic inequalities have significant impact on health, including for mental health. This results in an emphasis on what is referred to as "coexistence and mental health".

2018: Colombia releases its new and latest ***National Mental Health Policy*.** The concept of "coexistence and mental health" is fully embedded in this policy, which calls for policies to ensure the inclusion of people with mental health issues in educational, social and workplace environments. The plan includes a multi-level governance strategy with shared responsibilities between different levels of government.

2019: Colombia releases the **Integral Policy for the Prevention and Care of the Consumption of Psychoactive Substances.** This plan recognises the close interlinkages between mental health and the consumption of psychoactive substances, and thus shares five common work lines with the National Mental Health Policy. These are a) promotion of good mental health, b) prevention of mental illness, c) integral treatment, d) integral rehabilitation and social inclusion, and e) sectoral and inter-sectoral management.

2020: the National Council of Economic and Social Policy on Mental Health (CONPES) releases the ***2020-24 Strategy for the Promotion of Mental Health***. The strategy is notable for the wide range of government agencies involved and the specific mandates given to each government agency. The Strategy reflects an integrated approach to mental health that takes into account the social, employment and educational dimensions of mental health policy.

Sources: Plan Nacional de Salud Pública 2007-10 (2007), Ministry of Social Protection, https://www.paho.org/hq/dmdocuments/2010/Politicas_Nacionales_Salud-Colombia_2007-2010.pdf; Ten-Year Public Health Plan 2012-21 (2020), Ministry of Social Protection, https://www.minsalud.gov.co/English/Paginas/Ten-year-public-health-plan.aspx; Ley 1616 de 2013 (2013), Congress of Colombia; Política Nacional de Salud Mental (2018), Ministry of Health and Social Protection, https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/PP/politica-nacional-salud-mental.pdf.

Awareness raising efforts are increasingly widespread

Over the past five years, awareness-raising campaigns have been run across many countries at different stages in their mental health policy. This is reflected in the responses to the OECD Mental Health Benchmarking Policy Questionnaire, in which 27 countries stated that they had at least one national or regional anti-stigma or mental health literacy programme (OECD, 2021[4]). In some countries, where there is greater stigma surrounding mental health, awareness raising is emerging as a key priority in the development of an integrated mental health, skills and work policy. In others, awareness-raising campaigns have existed for decades, and in many cases, successfully started a conversation surrounding mental health that continues today. In both of these broad categories, countries are taking innovative steps to raise awareness further among the general public and front-line actors.

Awareness raising is a key priority in countries shifting towards community care

For many OECD countries, awareness raising goes hand-in-hand with a policy focus on shifting away from institutionalised care and towards supporting community care. These countries tend to consider the fear and misconceptions about the “mentally ill” to be a key obstacle to ensuring the acceptance of individuals experiencing mental health issues in the community, and thus see increased awareness as an enabler of the reform of their mental health systems.

One of the clearest examples to address the negative links between stigma and institutionalised care is in Latvia, where the *Cilvēks, nevis diagnose* (Human Not Diagnosis) anti-stigma campaign launched in 2018 aims to make people aware of why deinstitutionalisation is necessary and encourages the public to support a shift towards more community-based social services. The campaign has been run by the Ministry of Welfare, and tells the experiences and stories of individuals experiencing mental health conditions to promote empathy and a better understanding of their capacities, rather than limitations. The awareness campaign was combined with efforts to develop community-based services for individuals with mental health conditions. According to the policy questionnaire response, 20% of Latvia’s population had heard about the campaign by the end.

In Estonia, there are two campaigns notable for their emphasis on self-awareness and on encouraging people with mental health conditions to open up. “I’m all right”, launched by the Ministry of Social Affairs in 2017, targeted young people aged 13-16 through a video campaign and encouraged them to seek help and talk about their concerns. Meanwhile, in 2018, *Peaasjad* (Head Matters), an Estonian non-governmental organisation ran a campaign to raise self-awareness of depression with support from the Ministry of Social Affairs. The campaign encouraged individuals concerned by their mental health to complete an anonymous online screening test using a ten-item depression scale. As of March 2018, as many as 20 000 individuals had taken the test, with uptake of the online test conducted in over 30 organisations. Other OECD countries including the Czech Republic and Poland have also recently put in place national-level awareness raising campaigns. Examples of mental health awareness campaigns in the Czech Republic are discussed in Box 3.3.

A running theme in these awareness campaigns is the funding from the European Social Fund and the European Economic Area and Norway Grants, which indicates that these countries are closely aligned with the increased focus on mental health seen in Europe as a whole. At the same time, this does not mean that all OECD countries in comparable situations in Europe have national mental health awareness campaigns. Greece, for example, has not had a national awareness campaign since its last initiative ended in 2013. Meanwhile, in Slovenia, while the National Mental Health Plan for 2018-2028 stresses the importance of addressing stigma, the existing campaigns remain locally based, although there are plans to put in a place a national anti-stigma campaign.

Box 3.3. Raising awareness of mental health in the Czech Republic

In 2017 to 2018, the National Institute of Mental Health of the Czech Republic launched *Na Rovinu* as a national campaign to address stigma towards individuals with mental health conditions, which is particularly high in the Czech Republic. For example, only 25% of those surveyed in 2015 said that they would not mind working with someone with a mental illness.

The concept behind *Na Rovinu* is to encourage all actors in society to speak plainly or frankly about mental health – including individuals experiencing mental health conditions – and to deepen public understanding of mental health issues. The key target groups identified in the project are individuals with mental health conditions and their relatives, as well as among paramedics, social workers and the public administration, as these are groups that regularly engage with individuals with mental health conditions.

The *Na Rovinu* website acts as a hub with information on mental health. This includes, for example, tips on how to communicate in a non-stigmatising manner about mental health, the rights of individuals with mental health conditions, and facts and myths surrounding mental health. The personal stories of individuals with lived experiences of mental health conditions are also shared with consent both through the website and social media in an attempt to bring mental health in to day-to-day discussions. *Na Rovinu* also organises events to educate and inform the public on mental health, including on mental health considerations amidst the COVID-19 crisis, as well as aligning campaigns with international movements such as World Mental Health Day.

The *Na Rovinu* project is complemented by mental health awareness initiatives run by non-governmental organisations. This includes *Můj Mindset* (My Mindset), which was started in 2016 and ran a video campaign to tackle prejudice with support from government agencies and Norway Grants, and *Nevypusť duši* (Don't Drain the Soul), a non-profit organisation founded in 2015 which runs workshops for high school students in the Czech Republic, drawing on examples of successful awareness-raising campaigns in the United Kingdom.

Looking ahead, efforts to raise awareness of and address stigma associated with mental health conditions will remain a priority for the Czech Government. In the National Action Plan for Mental Health 2020-30, one of the key objectives for the Ministry of Health is the continued implementation of a nationwide mental health anti-stigma campaign. Non-governmental organisations were consulted in the process of developing this action plan.

Sources: NA ROVINU (2020), NA ROVINU, www.narovinu.net; STOP STIGMATIZACI! KAŽDÝ ČLOVĚK SI ZASLOUŽÍ POROZUMĚNÍ (2020), Můj Mindset [My Mindset], www.mujmindset.cz; Nevypusť duši: Nebojíme se mluvit o duševním zdraví (2020), Nevypusť duši [Don't Drain the Soul], www.nevypustdusi.cz.

Established awareness activities and campaigns are being built upon

In a number of OECD countries, awareness-raising and anti-stigma programmes have existed for decades, and these activities are being continued and strengthened. Although countries take varying approaches, these campaigns tend to be largely delivered by non-governmental organisations, reflecting their particular importance in awareness-raising activities. These programmes often run throughout the year but are scaled-up around relevant awareness days such as World Suicide Prevention Day, Mental Health Awareness Week and World Mental Health Day.

In New Zealand, the main national anti-stigma programme continues to be Like Minds, Like Mine, a programme established in 1997 and funded by the Ministry of Health to reduce discrimination against and

encourage inclusion of those living with mental health conditions. Like Minds, Like Mine launched its most recent campaign, "Just Like, Just Listen", in 2018, which promotes individuals to ask and listen to the experiences of those with mental health conditions, rather than assuming their needs or capabilities. While the strategic responsibility for the programme lies with the Ministry of Health, the Mental Health Foundation of New Zealand, a prominent non-governmental organisation, leads the communications around the programme. Another example of a well-known government-funded mental health campaign is Opening Minds in Canada, established in 2009 by the Mental Health Commission of Canada, which is funded by Health Canada and operates at an arm's length from government.

In France, Psycom, financed by Public Health France, the Ministry of Health, and regional health agencies, provides a hub for information on mental health. The public information body provides information to authorities on mental health, as well as tools to fight against stigmatisation and discrimination of individuals experiencing mental health issues, and training. Although Psycom was established as far back as 1992, it was only in 2015 that its mission was expanded from the Paris region to the national level. One notable recent activity by Psycom has been to map the growing number of information sources available on mental health across the country at the request of Public Health France. The exercise culminated in a report published in 2020, which found that while information on mental health may be increasingly available, knowing what information is relevant and of high-quality is becoming increasingly difficult (Psycom, 2020[10]). This shows a key challenge that countries may face as awareness-raising activities proliferate and sources of information become disperse and wide-ranging.

Independent activities by non-governmental organisations are also playing a prominent role and have significant outreach. In the United Kingdom, the Time to Change campaign (2007 to 2021), developed by Rethink Mental Illness in partnership with Mind, contributed to awareness raising for more than a decade, offering a model for other programmes to follow. By its conclusion in March 2021, the campaign had worked with more reached out to more than 1500 employers and 3500 employers (Time to Change, 2021[11]). Meanwhile, the Mental Health Foundation has run a large scale campaign on mental health since it set up the Mental Health Action Week in 2001, which has since become the Mental Health Awareness Week. Other prominent charities such as the Mental Health Foundation and the Royal Foundation of the Duke and Duchess of Cambridge are also running their own campaigns. Other countries such as the United States and Australia also have significant charities and non-governmental organisations that raise awareness of mental health issues and have an international reach.

Among initiatives by non-governmental organisations since the adoption of the Recommendation, Heads Together founded in 2016 by the Royal Foundation of The Duke and Duchess of Cambridge is a notable recent and ongoing initiative. Spearheaded by the Duke and Duchess of Cambridge, the initiative seeks to "change the conversation on mental health" working closely with partner organisations. As part of this initiative, the Heads Up campaign was launched in 2019 together with the Football Association. The campaign was driven by leading football players talking about mental health, and the dedication of the 2020 Football Association Cup to generating conversation on mental health.

Since 2012, there has also been a Global Anti-Stigma Alliance, which brings together well-established campaigns to promote mutual learning. The most recent meeting in 2017 was hosted by the ONE OF US organisation with partial funding from the Danish Health Authority. Representatives from more than 10 national anti-stigma programmes attended the meeting, and shared evidence and lessons learnt from their respective programmes.

Awareness raising increasingly goes beyond the health system

Awareness-raising campaigns across the OECD are also increasingly focusing on young people and the workplace, and stressing that addressing the stigmatisation of mental health requires the involvement of all actors in society. In most national campaigns, children and young people are explicitly stated as a target and there are also networks and non-governmental organisations dedicated to raising awareness of mental

health among younger audiences. These activities combined with the inclusion of mental health in school curricula promote greater awareness and literacy of mental health issues.

While workplaces are not covered as frequently by awareness raising programmes, there are a number of noteworthy recent initiatives that seek to raise understanding of the close interlinkages between the working environment and mental health. This is a promising trend. For example, the Netherlands has made raising awareness of work-related stress a priority of its occupational health and safety policy. As part of this, a “Week for Work-related Stress” has been organised every November since 2014, with activities organised on each day of the week on different themes. In 2019, “Masterplan Monday” was dedicated to both employers and employees developing plans and conversation techniques together to reduce work-related stress and improve well-being at work.

Meanwhile, in the United Kingdom, *See Me*, the Scottish programme to tackle mental health stigma and discrimination, implemented an evidence-based and highly effective anti-stigma campaign aimed at the workplace. *See Me* commissioned a poll and found that for both employers and employees, there was fear surrounding mental health as a topic in the workplace, with 48% of individuals responding that they did not tell their employers about mental health problems for fear of losing their job. Based on these findings, *See Me* launched their The Power of Okay campaign in November 2015, which encouraged individuals to ask the simple question, “Are you okay?” and put the audience in the shoes of the challenges related to mental health that both employers and employees might face in their day-to-day working lives.

Health care systems emphasise mental health, but the shift towards integration with skills and work interventions remains slow

Recognition for the need for greater focus on mental health in the health system

Most countries recognise the need to strengthen mental health services in the health system including for people experiencing mild-to-moderate mental health conditions. This perspective is captured in the *Achieving Better Access to Mental Health Services by 2020* vision for mental health services in England (United Kingdom) released in the autumn of 2014, which states that: “for decades the health and care system in England has been stacked against mental health services and against the people who use them.”

Increasing the capacity and scope of mental health services thus appears to be a key priority, and one way to achieve this has been to expand the size of the workforce in the mental health system. New Zealand, for example, is currently implementing its *Mental Health and Addiction Workforce Action Plan for 2017-21*, while the United Kingdom’s mental health workforce plan published in 2017 set out a target to employ 19 000 additional members of staff in the mental health workforce by 2020 in the National Health Service.

The questionnaire responses also confirm that a number of countries continue to focus on shifting from hospital- to community-based mental health services. In these countries, the focus of health system reform seems to be on increasing availability and capacity of community-oriented mental health services. For example, in Poland, starting in July 2018, the government has been piloting 27 mental health centres that together can provide support to around 3 million people. Meanwhile, in Hungary, six health promotion centres were launched in May 2016 with the aim of identifying key mental health issues in specific districts, and collecting and evaluating good practice to prevent and treat mental health conditions. Other countries that mentioned measures to strengthen community-based mental health care included, but are not limited to, Greece and the Czech Republic.

Digital technologies are playing an increasingly important role

Since the adoption of the Recommendation, there has been a rapid expansion of a broader range of technology-enabled mental health services, much of which has been driven by increased investment from

the private sector. A recent study has found that over the past six years, global funding into mental health technology has increased almost five-fold from around USD 156 million in 2014 to USD 750 million in 2019 (Octopus Group, 2020[12]).[2]

In particular, app-based tools that provide low-threshold support and offer programmes designed to strengthen self-management, mindfulness and coping skills have boomed. One of the challenges with such apps is to ensure they deliver effective support for individuals experiencing mental distress (Anthes, 2016[13]). A promising initiative to address this potential issue has been the development of a National Health Services Apps Library in England (United Kingdom). Founded in 2017, this library offers a growing list of apps – including many designed to promote better mental health – that have been assessed as being "clinically safe and secure to use" (NHS, 2020[14]).

Investing in a range of digital health technologies including telehealth services, online programmes and app-based support seems especially timely given the ongoing COVID-19 pandemic, which has restricted face-to-face treatment, and resulted in increased reliance on remote treatment and support as examined in further detail in *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health* (OECD, 2021[4]). OECD countries could, for example, expand use of electronic cognitive-behavioural therapy (eCBT) for individuals with mild-to-moderate mental health conditions, and especially work-focused eCBT, given that it is less costly than face-to-face treatment and has potential for significant outreach, which may allow for more timely intervention and support.

In response to the onset of the pandemic, most countries acted quickly to scale up and introduce telehealth services dedicated to providing mental health support. The challenge is now to transform these emergency measures into well-integrated and established digital mental health services. A notable example of an integrated approach to using digital tools to increase access to mental health support is Finland's Mental Health Hub, which is described in Box 3.4. Building a future-focused and innovative mental health sector as called for by the OECD Mental Health Performance Framework requires countries to take initiative to leverage the possibilities of digital technologies to provide more timely access to mental health support.

Increasing the mental health competence of all health professionals

Closely tied to increasing the capacity of the mental health system is the need to ensure that health professionals – in particular, general practitioners (GPs) – have sufficient knowledge and training to ensure they have the competence and confidence to not only identify mental health conditions, but also to provide treatment and/or refer the individual to a mental health specialist where appropriate. In many cases, front-line actors in the health system already receive initial training in mental health, but may nonetheless benefit from receiving further training. Many countries have implemented policies to strengthen the mental health competence of health professionals over the past five years.

In the Czech Republic, for example, as part of reform to the primary care sector, GPs are currently being trained to increase their competence across all areas including mental health, and to support GPs in speedy and effective diagnosis of mental health conditions, the government has stated its intention to develop best practices and guidelines for diagnosing mental health conditions. Another example is Latvia, where as part of the new Mental Health Plan approved in 2019, GPs and nurses are being trained in mental health through educational programmes.

Going further, training for key health professionals can take an integrated mental health and employment approach. In Australia, there is a promising ongoing project funded by the government and conducted by researchers from Monash University to increase the understanding of the role of GPs in diagnosis and management of work-related mental health conditions. As part of this project, researchers designed clinical guidelines to assist GPs in diagnosing and supporting people in work experiencing mental health conditions. The guidelines were approved by the National Health and Medical Research Council in 2018, released in 2019, and are currently being disseminated (Mazza et al., 2019[15]).

Box 3.4. Finland's Mental Health Hub

In 2009, the Helsinki University Central Hospital developed an eService for individuals with mental health conditions called Mielenterveystalosta [Mental Health Hub] with funding from the government. The motive was to address the fragmented nature of mental health services and to provide better support for individuals in rural areas, which is especially pertinent in a country such as Finland with its low population density and ageing population. Mental Health Hub aims to provide more patients with more timely and better quality access to mental health support. At first, the initiative focused on providing services for the local community, but was expanded into a nationwide online service in 2015.

The Mental Health Hub is a free one-stop hub offering a variety of mental health services. Self-help tools are easily accessible on the hub and help to promote mental health literacy for individuals looking for information, and since 2014, individualised therapy programmes have also been available. For an individual with a referral, free consultations and professional-guided eCBT are also available, as the government covers medical fees. The range of therapies has been expanded significantly in recent years, with online therapy now available for depression, alcohol use, anxiety, panic disorders, bipolar disorder and eating disorders.

One of the innovative features of the *Mental Health Hub* is the symptom navigator, which allows users to be directed to the most appropriate form of support depending on the severity and nature of mental distress. The *Mental Health Hub* even includes a portal dedicated to health and social care professionals so that they can receive training in mental health support and access relevant materials and tools designed by HUS. Materials are designed for not only mental health specialists, but also health care professionals in primary care, nursing and third-sector organisations such as charities. The *Hub* has seen a rapid increase in use among the general population. In the autumn of 2015, there were around 53 000 unique monthly visitors which had risen to in excess of 200 000 unique monthly users by the spring of 2019.

Although the Hub cannot replace all face-to-face services, it holds great potential to transform the traditional doctor-centred health system. According to HUS, virtual visits cost around half that of in-person visits in the case of mental health treatment, and psychotherapists can treat three patients in the time it used to take to see one, which has resulted in the near elimination of waiting lists. It is worth noting that the Hub is only possible because Finland has invested in health data for decades. HUS has used an electronic patient information system for over 25 years, while the My Kanta patient portal allows all individuals with a Finnish personal identity code to access and interact with their health records.

One of the advantages of the Mental Health Hub is its scalability of the technology. This has allowed HUS to expand the Hub into a national virtual hospital called Health Village that goes far beyond mental health services. As of 2020, Health Village has 32 specialist hubs, 115 digital care pathways and 5 virtual knowledge centres with over 540 000 users per month. The expansion of the Health Village was funded by the Finnish Ministry of Social Affairs and Health, and made possible through collaboration with technology key partners such as Innofactor and Microsoft.

Sources: Digital Health Village (2020), Helsinki University Hospital, www.digitalhealthvillage.com/; What can the UK learn from Finland's approach to mental health? (2017), The Guardian, www.theguardian.com/health care-network/2017/apr/05/what-uk-learn-finland-approach-mental-health-nhs; Virtual Hospital improves patients' health care access, dramatically cuts costs (2017), Microsoft, www.customers.microsoft.com/en-us/story/helsinki-university-hospital-health-office-365.

In a number of OECD countries, the World Health Organization's Mental Health Gap Action Programme (mhGAP) has helped to initiate training of primary health care workers in mental health. The programme has played a prominent role in the Latin America and Caribbean region in recent years, with mhGAP implemented in all OECD countries in this region (Chile, Colombia, Costa Rica and Mexico). In Colombia, for example, with support from the Pan American Health Organisation (PAHO), close to 2000 non-specialised professionals in the health sector had already been trained through the mhGAP as of October 2019, while Costa Rica is currently implementing a proposal developed with PAHO to train primary health care workers in mental health.

Measures are being taken to reduce waiting times for mental health care

There is also a growing recognition among countries of the need to provide more timely access to specialist care in the health system. *Fit Mind, Fit Job* noted that individuals often face long waits – even in OECD countries with highly advanced health systems – to receive appropriate mental health care. At least ten OECD countries report having a waiting times target or guarantee in at least one area of mental health care, and a few OECD countries have separate targets specifically for children and adolescents (OECD, 2020[16]; OECD, 2021[4]).[3] In a number of these countries (Denmark, Finland and Norway), a growing proportion of people are being assessed or treated within maximum waiting time targets in recent years.

The United Kingdom recently established its first waiting time standards for mental health care. Since 2016, the National Health Service in England has had a target to ensure treatment within six weeks for 75% of people referred to the Improving Access to Psychological Therapies programme (IAPT), with 95% to be treated within 18 weeks as part of the *Improving access to mental health services by 2020* commitments. A number of other OECD countries are currently developing indicators to assess waiting times. In Canada, for example, since 2018, the Canadian Institute for Health Information has been working with federal, provincial and territorial health ministers to develop indicators to measure access to mental health and addictions services. One of the set of six indicators relates directly to waiting times for mental health care services.

OECD countries primarily consider long waiting times for mental health care to be an issue with the supply of mental health services, and have focused on reducing wait times by increasing service availability and/or resources for services as outlined in *Waiting Times for Health Services: Next in Line* (OECD, 2020[16]). Nonetheless, while less common, there are a few examples of specific waiting time policies that aim to incentivise faster provision of treatment. One example is in Denmark, which expanded its "free choice of hospital" to include treatment for mental ill-health in addition to physical illness. This means that since 2015, Danish citizens can choose to access a limited range of private hospitals in Denmark as well as hospitals abroad to receive mental health care if the hospital to which they are referred is unable to fulfil the waiting time guarantee of 30 days. The performance of regions is monitored and data made publicly available, with the 2018 update on the National Goals suggesting a promising trend of declining waiting times for both adult and child psychiatric care across all regions in Denmark in the period 2012-17. In 2018, 95% of all Danish patients were seen by a psychiatrist or assessed for mental health within the 30-day waiting-time target.

Initiatives from the health system to involve skills and work policy remain limited

Despite the clear emphasis on developing mental health systems integrated with social, educational and employment supports and interventions in many countries, the questionnaire responses suggest that many of the countries still do little in practice to integrate a strong focus on employment and education – as either determinants of mental health status, or as outcomes – within the mental health system itself. There are some examples of progress on this front, but the shift is relatively gradual and the implementation of integrated mental health, skills and work policy remains slow.

One of the most notable initiatives of integrating employment within the mental health systems is the Improving Access to Psychological Therapies (IAPT) programme that has been rolled out across England (United Kingdom) by the National Health Service. First piloted in 2008 and since expanded, the programme originally aimed to expand access to therapies for individuals with mental health conditions such as anxiety and depression. In the early years of the programme, employment advisors (EAs) were also introduced to work alongside therapists to provide practical advice and support to help people to remain in work or enter the workplace (OECD, 2015[17]). While a target of one EA for every eight IAPT therapists was set (1:8 ratio), in reality, in some services there was only one EA for as many as every 50 IAPT therapists.

Starting in 2017, the Work and Health Unit[4] has been investing GBP 39 million on recruiting EAs to provide more integrated mental health and employment support supporting people to remain in, return to or find work and to meet the 1:8 target ratio (Department for Work and Pensions and Department for Health and Social Care, 2017[18]). An evaluation report based on eight case studies from the first wave of the programme found that EAs in IAPT are well-received from relevant stakeholders, namely clients, therapists and employability partners, and early outcomes appear positive with clients citing increased confidence, improvements in mental health, and progress towards return-to-work (Loveless, 2019[19]).

A few other OECD countries have followed the example of IAPT and are implementing programme to increase access to therapies for individuals with mild-to-moderate anxiety and depression. Norway's Prompt Mental Health Care programme was launched in 12 Norwegian municipalities in 2012, but has since been expanded further. Between 2013 and 2019, 600 psychologists were recruited in Norway through a grant scheme to work in the municipalities, and since January 2020, all municipalities have been required by law to offer occupational therapy services. Meanwhile in Sweden, since January 2020, regions have been legally required to put in place rehabilitation co-ordinators within the health system. The core responsibilities of these co-ordinators will be to promote return-to-work through engagement with employers, employment agencies and public employment services, while they will also be required to support patients during their sick leave and rehabilitation process.

Youth support systems and education policies show significant progress

Of the four thematic areas covered by the Recommendation, the most significant progress is taking place in youth support systems. Mental health is understood by OECD countries to be critical for the development of youth, and policies in many cases follow the steps proposed in the Recommendation. This includes policies that target mental health directly, as well as policies supporting youth living with mental health conditions indirectly – such as support for early school leavers. There is also growing recognition of the need for early identification and timely support, as demonstrated by the increased focus on providing low-threshold and non-stigmatising mental health services that are easy to access for young people.

Timely intervention to prevent mental ill-health is a priority in schools

Many countries have attempted to ensure more timely action by putting in place whole-of-school approaches to identify mental health conditions among students, as well as signs of below-threshold mental distress that may be at risk of developing into clinical mental health conditions. Attempts to ensure timely identification and treatment in schools typically include a combination of policies to promote mental well-being and to prevent risky behaviours. These approaches share in common an attempt to address the exacerbation of mental health conditions among individuals by creating environments that are conducive to good mental health and are less likely to result in individuals developing (or aggravating existing) mental health conditions, and are often used to complement one another.

An example of a promotion approach to mental health in schools is Ireland's *Well-being Policy Statement and Framework for Practice* for 2018 to 2023. The framework not only sets out the government's vision for

well-being in schools, but also stipulates that every school in Ireland must implement a school self-evaluation process that follows the framework and looks at well-being in four key areas – culture and environment, curriculum, policy and planning, and relationships and partnerships. Australia also launched its *Australian Student Well-being Framework* in 2018, which provides schools with guidelines on promoting the well-being of students from the first year of school to year 12.

A number of OECD countries have taken more of a prevention approach, focusing on how to limit and prevent high-risk behaviours that are often associated with mental ill-health such as bullying, xenophobia, alcohol and substance use, violence and truancy. For example, in the Czech Republic, there is an ongoing *National Strategy for Primary Prevention of Risky Behaviour* that will run through to 2027, while in Poland, the Ministry of Education commissioned research on effective preventative and prophylactic programmes in schools, the results of which were made available in 2018.

Most OECD countries also report having anti-bullying programmes and strategies at the national level, and many referred to recently implemented measures and strategies to address bullying in schools in their policy questionnaire response. In Denmark, the 2016 *Action Plan for Preventing and Combating Bullying* sets out recommendations for the state, local governments and other organisations to reduce bullying in schools and recognises the importance of anti-bullying measures to promote mental health in schools. Meanwhile, in 2018, Norway established anti-bullying ombudsmen in every county to support and give advice to pupils and parents regarding school safety. A report released in 2020 found that while challenges remain in providing ombudsmen themselves with adequate support in fulfilling their mandate and with ensuring equal access to support across region, the ombudsmen scheme has helped to create a safer environment for children in kindergarten and at school (Seland et al., 2020[20]).

New Zealand is also implementing national-level face-to-face assessments of the mental well-being of secondary students in an attempt to ensure early identification of possible undisclosed or undiagnosed mental health conditions. This involves rolling out the *HEEADSSS Wellness Checks* – an interview-based face-to-face assessment consisting of questions relating to home (H), education and employment, eating and exercise (E), activities (A), drugs and alcohol, depression and suicide (D), and sexual health, safety and personal strengths (S) – to Year 9 students across the country. These assessments were initially implemented as part of the *Youth Mental Health Project*, which was launched in 2012. As of 2019, these wellness checks were performed in 40% of secondary schools, and further extensions are planned.

These in-school early identification measures are also complemented by low-threshold and non-stigmatising mental health support services outside schools for young people in many OECD countries. Examples include *Ohjaamo* one-stop guidance centres in Finland, and headspace services in Australia. By avoiding labelling individuals as sick or problematic, such services can encourage children and young people to seek support when showing first signs of mental ill-health. This can help to ensure treatment and support is made available early before individuals experience more severe mental health conditions and before they have lost connection with schools, apprenticeships or the workplace.

The key to both in-school and out-of-school measures is to ensure they are followed up by timely and appropriate intervention when mental distress or possible mental health conditions are identified, including where appropriate, through referrals to specialists. It is crucial that these measures are complemented by strengthened links and transitions between youth support systems and the mental health system that can help to ensure timely follow-up. In this context, England's Link Programme provides a promising example. As discussed in Box 3.5, the programme brings together education professionals from schools and mental health professionals from the health system to strengthen collaboration, with evidence from the pilot stage suggesting that the programme is strengthening the quality and timeliness of referrals from schools to the health system.

Box 3.5. Mental Health Services and Schools and Colleges Link Programme – England (United Kingdom)

The *Mental Health Services and Schools and Colleges Link Programme* is an initiative launched in 2015 funded by the Department of Education and supported by NHS England, which seeks to promote mutual understanding and strengthen communication between educational institutions and mental health services.

The programme centres around two one-day workshops held around six weeks apart in which education and mental health professionals come together to share “local knowledge and resources” under the leadership of local Clinical Commissioning Groups, which are in charge of planning and commissioning mental health services in their local areas. The workshops use a specially designed framework known as CASCADE, which consists of seven domains, namely:

Clarity on roles, remit and responsibilities of all partners involved in supporting children and young people’s mental health.

Agreed point of contact and role in schools/colleges and children and young people’s mental health services.

Structures to support shared planning and collaborative working.

Common approach to outcome measures for young people.

Ability to continue to learn and draw on best practice.

Development of integrated working to promote rapid and better access to support.

Evidence-based approach to intervention.

The *Link Programme* began as a pilot initiative in schools between 2015 and 2016 that involved 255 schools. An independent evaluation of the pilot found that it had significantly strengthened communication and joint working between schools and mental health services, improved the quality of referrals from schools to specialist mental health services and even raised the knowledge and awareness of mental health among school staff not directly involved in the initiative.

After the success of the pilot, the Department of Education commissioned the Anna Freud Centre for Children and Families, a non-governmental organisation, to expand and roll out the initiative across the country. Between 2017 and 2019, over 3 000 school, college and mental health professionals took part, and the programme is currently being scaled up to reach every school and college in England.

By strengthening communication and joint work between the health and school systems, the *Link Programme* is playing a dual role of improving timeliness of support for children and adolescents with mental health conditions through more effective referrals (addressing the “when” and “what” dimension) as well as raising awareness of mental health issues among educational professionals (improvement on the “who” dimension).

Source: Link Programme (2020), Anna Freud National Centre for Children and Families, https://www.annafreud.org/schools-and-colleges/research-and-practice/the-link-programme/; Mental Health Services and Schools Link Pilots: Evaluation report (2017), Ecorys UK, https://www.annafreud.org/media/9751/evaluation_of_the_mh_services_and_schools_link_pilots-rr.pdf.

Efforts to increase mental health competence of teachers and educators are widespread

Most OECD countries provide some form of training on mental health to teachers, educators and other front-line education professionals who regularly engage with students, although in some countries, coverage of such training remains limited. The importance attributed to training teachers is reflected in the responses to the OECD Mental Health Benchmarking Policy Questionnaire: 19 out of 27 responding countries said they provided "some" or "a lot" of mental health training to teachers, with only five stating that they provided no training. This is more than the 16 countries reporting they provide training to unemployment service counsellors or staff (OECD, 2021[4]).

Australia continues to take significant steps forward in this field. In November 2018, a government-funded initiative called *BeYou* was launched that provides teachers with the tools to help support the mental health of children. The service is free and available to educators, schools and early learning services in Australia, and integrates past school-based programmes such as *Kids Matter* and *Minds Matter*. As an example, *BeYou* has an Educators Handbook for both early learning services and primary and secondary schools, providing guidelines for educators on how to improve the mental well-being of students.

In Ireland, the National Education Psychological Service (NEPS), which supports teachers in promoting the mental health of students in primary and post-primary schools, has been expanded in recent years. In 2019, 19% of the total education budget was allocated to achieving better education and life outcomes for children with special needs, and as part of this, additional psychologists were recruited to NEPS to support students with complex educational needs (Government of Ireland, 2019[21]). NEPS also provides specific support to school leaders and teachers in establishing student support teams in schools, including through an assigned NEPS psychologist.

In some OECD countries, where training may not provide competence in mental health *per se*, teaching curricula increasingly emphasise the importance of socio-emotional skills that can help build mental resilience and promoting positive mental health. For example, in Mexico, there is an ongoing national programme, with over 2 million participants, that seeks to support socio-emotional learning in secondary public schools. After an evaluation of the programme in 2016 found there were not enough staff qualified or with the skills to teach about socio-emotional skills, directors and teachers from more than 4 200 public high schools were trained through dedicated workshops.

One of the most prominent tools being used to train teachers and educators in mental health is *Mental Health First Aid* (MHFA) and similar programmes that offer courses to provide lay people with evidence-based education on mental health to help them recognise, understand and respond to signs of mental ill-health. Since being first established in Australia, in 2001, there are now licensed providers of mental health first aid in 27 countries that have together trained more than 3 million people worldwide. While MHFA can be taken by anyone and is not limited to schools, many OECD countries have set targets to expand training in schools through these programmes. For example, in the United Kingdom, in 2017, the government announced a plan to make mental health first aid training available in all secondary schools by 2020. As of March 2020, over 2 500 schools had been reached through this plan.

In comparison, the United States has taken a slightly different approach. The Substance Abuse and Mental Health Services Administration has awarded grants to state and local educational agencies as well as non-governmental organisations in recent years to ensure teachers and school leaders have awareness of mental health issues and competence to support students experiencing mental ill-health. This has been done most notably through the "Mental Health Awareness Training Grants" and "Project Advancing Wellness and Resiliency in Education State Education Agency Grants". In 2018, the amount of funding available through these grants totalled almost USD 59 million, while USD 31 million was made available in funding through the latter grant in 2020 (SAMHSA, 2020[22]).

Preventing early school leaving is being prioritised in several OECD countries

When it comes to specific interventions and policies, there is progress in many OECD countries to prevent early school leaving and provide non-stigmatising support. As outlined in *Fit Mind, Fit Job,* investing in the prevention of early school leaving and support for school leavers with mental health conditions is crucial. Early school leaving is more prevalent among young people living with mental health conditions in comparison to those with no mental health conditions, and thus measures to address early school leaving are an important ingredient of an integrated mental health, skills and work policy.

Preventing early school leaving is a priority for the European Commission, with all EU member states having committed in 2010 to reduce the share of early school leavers to under 10% by 2020. While progress has differed from country-to-country, the rate of early school leaving has continued to gradually decrease across the EU-28, and stood at 10.3% as of 2019 (Eurostat, 2021[23]). The priority placed on reducing early school leaving and supporting students to graduation is reflected in Hungary and Latvia where new policies have been implemented since 2015. Hungary is currently in the implementation stage of its “Mid-term Strategy against Leaving School without Qualification (2014-2020)”. Early warning and pedagogical support systems to prevent early school leaving were first introduced in November 2016, with the system monitoring risk factors for early school leaving such as absenteeism, difficulties in integration and underachievement. These factors closely align with the risk factors for mental ill-health. Once identified, at the school level, individual plans help students at risk through support that is co-ordinated and integrated with social workers, psychologists and child welfare services. To complement these implementation measures, teachers are trained on how to identify students at risk of early school leaving. In Latvia, the *PuMPuRS* project also provides individualised support to students at risk of early school leaving. By August 2020, the project – launched in 2017 with funding from the European Social Fund – had involved 527 educational institutions and created 43 695 individual aid plans.

Low-threshold and non-stigmatising mental health support for children and young people

The Recommendation calls for non-stigmatising support for children and youth living with mental health conditions. The policy questionnaire responses indicate that there are a number of well-integrated, external – in other words, out-of-school – and low-threshold mental health supports and services that have further developed in recent years. Such services usually take the form of youth centres that go hand-in-hand with in-school measures to support individuals with mental health conditions. These centres can help to avoid labelling young people as sick and problematic, and encourage them to seek support when showing first signs of mental ill-health, long before a mental health condition has been diagnosed.

Australia’s headspace centres offers a working example of a low-threshold service that already offered non-stigmatising support to young people aged 12 to 25. In the financial year 2018-19, almost 100 000 young people visited a headspace centre and a further 32 000 accessed online and phone counselling through eheadspace. The number of headspace centres has been increased from 82 in 2015 to 112 in 2019, and additional funding of AUD 263.3 million from 2018-19 to 2024-25 was announced to help meet the high demand for mental health services (Australian Government Department of Health, 2019[24]). Since 2016, headspace is being used as the delivery site for a pilot of integrated and individualised mental health and employment support for young people with mild-to-moderate mental health conditions.

Another example of a low-threshold service targeted at young people is Finland’s *Ohjaamo* centres, which are one-stop youth guidance centres that offer integrated agency interventions including psychosocial support. Finland recently concluded a project to implement a national model of psychosocial support for *Ohjaamo* centres to ensure earlier identification of psychosocial issues. The government has since decided to continue to support the project through 2021 and 2022.

Scaling up mental health supports for young people in the school-to-work transition

The policy questionnaire responses also indicate that a number of countries have taken action to support the transition from school to higher education and work, but the emphasis is often not directly placed on mental health. In Denmark, for example, a broad political agreement was reached in 2017 to reform the financing system of universities so that educational institutions are eligible for financial compensation for the extra time that some groups – such as students with disabilities – may need to complete their studies. While there is no explicit focus or mention of mental health in the policy itself, extra time can often enable and support students with mental health conditions to complete their degrees.

In contrast, the United Kingdom is taking measures to specifically support the mental health of youth in the transition from school to higher education. In 2019, the Department for Education set up a taskforce to support students in maintaining good mental health when starting university. The taskforce will focus on four main areas that can affect the mental health of students going into university, namely: independent living, independent learning, healthy relationships and well-being. The taskforce is in its initial phase with the focus currently on spreading existing good practices such as the "Transitions and Know Before You Go" initiative run by *Student Minds*, a mental health charity based in the United Kingdom.

In the United States, an interesting initiative is being run by "The Learning and Working During the Transition to Adulthood Rehabilitation Research & Training Center" at the University of Massachusetts Medical School. While this centre operates mainly in the health system, its focus is on supporting young people with mental health conditions in their transition from learning to working. For example, the centre has produced employment-related tips sheets for young jobseekers with mental health conditions that address practical questions such as "Do I Tell My Boss?", as well as a toolkit for employers of youth and young adult peer recovery workers. The US Government was providing large-scale funding to the centre, through the Department of Health and Human Services, from 2014 to 2019.

Workplaces are addressing psychosocial risk, but return-to-work support remains limited

Most countries reported taking action on workplace policies to reduce psychosocial risks at work and create more mentally healthy and safe working environments. OECD countries have been making progress in this area through a mix of regulations relating to psychosocial risk assessment and prevention, and guidelines for employers and line managers to develop mentally healthy workplace environments as called for by the Recommendation. Yet at the same time, workplace policies are often not integrated with the mental health care system, or with employment services and the social protection system. This is most apparent in policies to address long-term sick leave, which continue to be steered by the social protection system and public employment services, with few obligations or incentives in place for employers to support return-to-work in many OECD countries.

Psychosocial risk is being increasingly integrated in occupational health and safety

Many OECD countries have made significant progress in promoting and regulating psychosocial risk assessment and prevention in the workplace. In *Fit Mind, Fit Job*, a key finding was that implementation of such policies was slow and that traditional issues continue to dominate health and safety policies. The policy questionnaire responses indicate that most countries have moved beyond this stage, with many OECD countries in recent years putting into place strategies and regulations, and offering guidelines to reduce psychosocial risks in the workplace.

Many OECD countries have amended their regulations on occupational health and safety to incorporate psychosocial risks in a better way. In Canada, for example, a 2017 amendment to the Canada Labour

Code makes explicit that occupational health and safety applies not only to physical injury, but also to psychological illnesses and injuries. Following on from this, in 2019, Canada announced it was going to take measures to require federally regulated employers to take preventative steps to address workplace stress. In Spain, Royal Decree-Law 8/2019 introduced mandatory registration of working hours, as a means to hold employers accountable for excessive work hours and unpaid overtime, both of which are risk factors for mental ill-health.

Japan, meanwhile, is a notable example that has placed stronger requirements on employers. Since December 2015, employers with more than 50 employees have been obliged to offer a “stress check” at least once a year. In 2018, 80.3% of employers offered the stress check (MHLW, 2019[25]). Based on the overall findings, employers are obliged to make their best efforts to adjust the work environment to reduce psychosocial stress. Japan has also linked the “stress check” policy to health services. If an employee is recognised as having high stress, they are entitled to request their employer to arrange an interview or consultation with a physician. The employer is then obliged to ensure such an appointment is arranged, and must adjust the individual’s working conditions based on the findings of the physician as necessary. The use of questionnaires or tests to assess psychosocial risks in the workplace is also promoted in other OECD countries, although most take a voluntary approach. For example, the National Institute for Safety and Health at Work in Spain, which operates under the Ministry of Labour, has developed a questionnaire and accompanying app known as FPSICO, which can be completed to provide insights into possible psychosocial risks in the workplace.

Many countries have also developed tools to support companies in implementing workplace psychosocial risk assessment and prevention. In Colombia, for example, the Ministry of Labour established not only a set of instruments for the evaluation of psychosocial risk factors in the workplace, but also a guide for the promotion, prevention and intervention on psychosocial risk, both of which were adopted in 2019. In Japan, meanwhile, a web portal called Kokoro no Mimi (Ears of the Mind) provides guidelines and tools for employers and managers to support the mental health of employees, and to implement the stress check. In Spain, as part of the Spanish Strategy for Occupational Health and Safety 2015-2020, the government is developing new guidelines on the management of psychosocial risks. Such guidelines and tools can help businesses and employers implement measures that align with regulation on reducing psychosocial risks at work.

Where OECD countries differ is in how broadly they look at mental health in the workplace. In many countries, these measures are primarily designed to prevent mental health conditions from arising. By defining mental health policy in the workplace narrowly, this preventative approach may only bring benefits for individuals who experience clinically significant symptoms of mental health conditions. In comparison, there are significantly fewer OECD countries seeking to promote better mental health for all employees.

The United Kingdom and Canada stand out as two OECD countries that are taking this broader approach to mental health policy in the workplace. In the United Kingdom, the government is implementing recommendations from *Thriving at Work: the Stevenson/Farmer review of mental health and employees*, commissioned by the Prime Minister and published in 2017 (UK Government, 2017[26]). The review called for emphasis on ensuring mentally healthy workplaces rather than simply dealing with mental health issues when they arise. The recommendations were accepted by the government, and working closely with leading charities, employers and interagency co-operation, a set of six Mental Health and Work standards were developed that any employer can follow to support the mental health of their employees, as well as tips on how to implement these standards. In a similar vein, Canada’s National Standard for Psychological Health and Safety, which is discussed in detail in Box 3.6, provides guidelines on how to promote more psychologically healthy and safe work environments for all employees.

Box 3.6. National Standard for Psychological Health and Safety in the Workplace – Canada

Canada's National Standard for Psychological Health and Safety in the Workplace (the Standard), first established in 2013 under the leadership of the Mental Health Commission of Canada (MHCC), is a set of voluntary guidelines that support employers in developing "psychologically healthy and safe work environments for their employees". The Standard aims to contribute to broadening understanding of Occupational Health and Safety by "shifting workplace culture to value mental health and safety as much as physical health and safety".

Compared to other frameworks on mental health in the workplace, the Standard is much broader, and identifies 13 factors for improving psychological health and safety in the workplace. For example, instead of simply focusing on more narrow factors such as workload management and access to counselling, the Standard also stresses the importance of factors such as organisational culture, providing opportunities for employees to grow and develop, and developing workplace environments where employees feel they are connected to their day-to-day work.

Although the Standard predates the Recommendation, in recent years, Canada has developed implementation guidelines and tools to support employers in translating the guidelines into changes in the workplace. In 2017, for example, the MHCC concluded a three-year project to look at how 40 organisations of varying size from different industries and sectors were implementing the Standard. The report from this project identified a number of good practices, as well as factors that may facilitate or act as barriers to implementing the Standard.

The Standard has also been accompanied by a set of animated videos developed in 2016 by the MHCC in partnership with Ottawa Public Health that seek to raise awareness of the 13 factors that can affect mental health in the workplace. Instead of simply raising awareness, the videos provide a thorough and detailed explanation of the interlinkages between workplaces and mental health with individual videos for each of the 13 factors. These videos have been integrated into the broader "have THAT talk" series developed by Ottawa Public Health that aims to raise awareness of the importance of mental health more broadly.

A 2019 poll by Ipsos found that while only a small proportion of employees are aware of the Standard, employees working for organisations that implement the Standard are far less likely to say their workplace is psychologically unhealthy or unsafe (5%) compared to organisations not implementing the Standard (13%). Furthermore, at organisations that implement the Standard, employees who have experienced depression took less days of work (7.4 days per year) than the average employee experiencing depression (12.5 days per year). This indicates that the Standard may already be contributing to an improvement in the mental health of employees.

Sources: National Standard of Canada: Psychological health and safety in the workplace (2013), Mental Health Commission of Canada; Workplaces that are Implementing the National Standard of Canada for Psychological Health and Safety in the Workplace Described by Employees as Psychologically-Safer Environments (2017), Ipsos, https://www.ipsos.com/en-ca/news-polls/workplaces-implementing-national-standard-canada-psychological-health-and-safety-workplace; Case Study Research Project Findings: 2014-17 (2017), Mental Health Commission of Canada, https://www.mentalhealthcommission.ca/sites/default/files/2017-03/case_study_research_project_findings_2017_eng.pdf.

One of the main recommendations from the Stevenson/Farmer review was to implement standards on healthy workplace environments within the Civil Service (2017[26]). As a leading employer, it is hoped that the Civil Service can demonstrate good practices for other employers to follow. Since the release of the independent report, the Civil Service has held its own mental health conference that aims to exchange and embed mental health best practices across the Civil Service. One such best practice may be the decision by HM Revenue & Customs to double the number of Mental Health Advocates available to ensure more colleagues can receive individualised face-to-face support.

More can be done to support return to work and reduce preventable sick leave

Increasing evidence from studies in a number of OECD countries shows that combining workplace measures with clinical interventions is more effective than isolated workplace or clinical treatment at supporting employees experiencing mental health issues to remain in and return to work, and thus that integrated support can both prevent and shorten absences due to sickness (Nieuwenhuijsen et al., 2020[27]). This confirms and provides support to the Recommendation's emphasis on promoting timely return-to-work and reducing preventable sick leave of those experiencing mental health conditions. Despite this, there has been limited progress to reduce preventable sick leave, and even in cases where there are promising initiatives, these tend to be focused on adjustments to the social protection system as opposed to strengthening the role of employers for addressing mental health issues of employees on sick leave.[5]

Austria and Denmark have implemented new measures and reforms of the social protection system to prevent long-term sick leave that should be followed closely. In Austria, a new model to promote part-time return to work (WIETZ) was introduced in 2017, in which workers are entitled to shorter working hours and financial protection to support reintegration into the labour market after prolonged sick leave. Since its introduction, more than 7 300 individuals have used the WIETZ model to return to work. Although WIETZ is not exclusively for individuals with mental health conditions, mental ill-health is the most common reason for prolonged absence from work among WIETZ applicants.

Meanwhile, Denmark launched a project in 2015 to trial a model to support return-to-work called IBBIS. The IBBIS model offers integrated support from case managers in the social protection system, employment consultants and health care professionals to support individuals with mild-to-moderate mental health conditions – depression, anxiety and stress orders – return to work after prolonged sick leave (Mental Health Services in the Capital Region of Denmark, 2020[28]). This project has since been further updated to IBBIS II, and will continue through to 2022. This is a rare example of integrated employment and mental health support that is specifically targeted at individuals on sick leave, as opposed to jobseekers who are out of work.

In contrast to reform of social benefits and employment services, policies to incentivise or require employers to prevent long-term sick leave were rarely mentioned in the policy questionnaire responses. This suggests the continuation of a worrying trend mentioned in *Fit Mind, Fit Job*: employers are only held responsible for the mental health of their employees while they are still at work. This may also reflect a lack of clarity on the roles and responsibilities for ensuring support for return-to-work – in many OECD countries, after a period of prolonged sickness absence, there appears to be a gap between the point where employers are responsible and where the support of the employment service and social protection system kicks in.

There are a few examples of stronger requirements and incentives for employers to support return-to-work among employees on sickness absence, but most pre-date the Recommendation. In the Netherlands, employers are obliged by law to provide payment of at least 70% of wages for two years to their employees on sick leave (OECD, 2015[17]). Furthermore, by 2015, in the Netherlands, Norway and Sweden, employers and their corresponding employee both had responsibilities to agree to return-to-work action plans after around eight weeks of sick leave. However, these OECD countries remain exceptions to the norm.

In the questionnaire responses, only Sweden explicitly mentioned measures it had taken to increase the role of employers in supporting return-to-work. Since July 2018, employers in Sweden have been required to draft return-to-work plans for employees within 30 days of onset of sickness absence for employees who are not expected to return to work within 60 days of onset of absence. Employers in Sweden can now also apply for a grant from the Swedish Social Insurance Agency to subsidise costs related to providing workplace-oriented rehabilitation. These combined efforts should provide further encouragement to employers to take greater responsibility in supporting their employees return to work.

Welfare systems show the least progress, with individualised support lacking

Across all OECD countries, recognition of the key role of the social protection system in fostering an integrated policy approach to mental health remains limited. In the few examples where social benefits and employment support have a focus on integrated health and employment support, this is generally targeted at (and limited to) severe mental health conditions – through either a focus on mental health within disability policy, or investments in supported employment (Individual Placement and Support). Although efforts to improve the mental health competence of caseworkers and other actors have been made in recent years, it seems that the high prevalence of mild-to-moderate mental health conditions among people receiving benefits is yet to be fully recognised and reflected in policy in most OECD countries.

Rules and legislations are being reformed to encourage and support return to work

A number of countries have undertaken significant reforms to rules and legislation in social benefits and employment services to incentivise jobseekers experiencing mental health conditions to return-to-work. For example, Canada amended its Employment Insurance (EI) rules effective August 2018 to extend to maternity and sickness benefits. This provision allows EI claimants to work while receiving benefits by providing mothers and those dealing with illness or injury with greater flexibility to gradually return to work. These EI claimants can keep 50% of their benefits for every dollar earned, or up to 90% of previous weekly insurable earnings used to calculate their EI benefit amount. Although not directly targeted at individuals experiencing mental health conditions, this change supports jobseekers financially, including those with mental health conditions, to gradually return to full-time work without risking the loss of benefits.

In Finland, the recently launched work ability programme will adjust rules on benefits to allow individuals with partial working capacity – such as individuals experiencing mental health conditions – to gradually return to work while keeping part of their existing unemployment benefits. Furthermore, in Lithuania, in-work benefits have been extended so those registered as unemployed for at least six months can keep half of their benefits temporarily after finding work. These reforms in Canada, Finland and Lithuania are promising measures that follow in the footsteps of Sweden and Norway, which were identified as countries already supporting gradual return to work in *Fit Mind, Fit Job*.

The policy questionnaire responses also indicate that some countries have recently reformed work capacity assessments by shifting towards identifying capacity – even if partial – and away from disability. For example, in Estonia, the government has recently started to reassess workers on disability benefits to identify individuals with partial work capacity. Initially, in 2016, the measure was implemented on a voluntary basis, but since 2017, individuals with partial work capacity have been required to register as unemployed. Most importantly, the recognition of their work capacities opens up channels to specific and well-targeted employment support. Early signs are promising as many of the initial participants have chosen employment support that is usually targeted at the unemployed, such as training, work trials and work-related rehabilitation (Browne et al., 2018[29]). Estimates from the Ministry of Finance suggested that by 2022, an extra 19 100 people would be in employment and 16 400 more people actively looking for work due to the reform.

Individual Placement and Support programmes need to be scaled up

Fit Mind, Fit Job noted that there were a number of promising examples of employment support being combined with mental health care especially through Individual Placement and Support (IPS), a proven evidence-based practice in which multidisciplinary mental health teams including an employment specialist provide co-ordinated health and employment support for jobseekers in finding and sustaining employment in a competitive setting. The participants are usually individuals who receive mental health treatment through specialist mental health and addiction services.

The policy questionnaire responses indicate that IPS has become more widely implemented across the OECD. This has been mainly throughout trials to test and evaluate IPS programmes for jobseekers with severe mental health conditions. There are ongoing or recent IPS trials in many OECD countries including Denmark, Finland, Ireland, Italy, the Netherlands, Norway and New Zealand. Such trialling and evaluation has proven the effectiveness of the IPS approach across multiple OECD countries. For example, in both Australia and Denmark, recent studies have shown that IPS programmes result in positive employment outcomes for participants, while there are also similar well-established findings in countries such as the United States that predate the Recommendation. Given that IPS has proven to be effective in multiple countries based on decades of research, countries would benefit more from scaling up or rolling out IPS, rather than continuing to pilot the standard IPS approach. Despite this, the policy questionnaire responses suggest that very few OECD countries have scaled up IPS trials and/or included them in national mental health strategies.

The challenge of scaling up IPS may indicate that while beneficial for the jobseeker receiving support, the approach might be considered too resource-intensive or too ambitious to be implemented at the national or regional level, even if it is cost-effective. IPS is rarely mentioned in mental health plans, with a few exceptions such as England (United Kingdom), where the NHS has committed to supporting 55 000 people per year with severe mental health conditions in finding and retaining employment by 2023/24. This may be because some of the principles of IPS which are usually strictly adhered to, such as time-unlimited supports, may not be easily met as IPS is scaled up. This has driven attempts to develop modified versions that may be less costly or easier to implement.

One of the policy questionnaire responses mentioned a modified version of IPS, Italy's "Traineeship as a Springboard out of Unemployment for those Affected by Mental Illness" project. The key premise of this project is to place participants in organised internships and traineeships lasting three to six months where participants can gain real-world experience in competitive employment settings. As the name of the project indicates, the aim was to assess whether such experience in internships and traineeships could then be used to upskill participants such that they can use the experience as a springboard from which to find competitive employment. It will be critical to evaluate the long-run impact of the project, as the effects on labour market outcomes are unlikely to be seen immediately.

Shortage of support for individuals with mild-to-moderate mental health conditions receiving unemployment benefits

A further limitation with IPS is that it usually focuses exclusively on supporting individuals with severe mental health conditions find employment. As a result, such individualised support is provided mainly to individuals who are recipients of disability benefits due to their existing mental health condition. This was also reflected in the policy questionnaire responses, as many of the responses interpreted the section on social protection systems exclusively as referring to disability policy. In comparison, there remains a lack of comparable integrated mental health support for recipients of unemployment benefits, many of whom may have diagnosed or undiagnosed mild-to-moderate mental health conditions.

This approach to mental health support does not reflect the fact that there are likely more individuals with mental health issues receiving unemployment than disability benefits. As shown in Chapter 2, among recipients of benefits who are experiencing mental distress in the OECD countries for which there is data,

37% are on unemployment benefits compared to 33% that are on disability benefits. This distribution varies across OECD countries. In Denmark, Germany, Spain and Austria, individuals experiencing mental distress are more likely to receive unemployment benefits, whereas in Estonia, Switzerland and Norway, individuals experiencing mental distress are more likely to receive disability benefits. Nonetheless, across the OECD, mental health support and services need to be available in all areas of the welfare and social protection system.

There are a few exceptions of integrated support directed at individuals with mild-to-moderate mental health conditions, often modelled on IPS, although these tend to still only be pilots or trials. In Australia, for example, a pilot launched by the Department of Social Services in 2016 aimed to provide IPS for around 2000 young people every year – targeting individuals with mild-to-moderate mental health conditions – through headspace services. An evaluation has found that the programme is effective in improving the education and employment outcomes of these young people (KPMG, 2019[30]), and a literature review has been conducted to assess potential adjustments to further strengthen the effectiveness of IPS programmes for young people. A cost-benefit analysis of the trial in 2020 found that while the implementation of IPS requires additional investment compared to existing employment services under "jobactive", the benefits gained in terms of reduced welfare payments and increased personal income far outweigh the additional costs (KPMG, 2020[31]). Given its success so far, in October 2020, the government announced a further expansion of the trial to a further 26 sites and the continuation of the trial in existing 24 sites through to June 2024. Similarly in both Wales and England (United Kingdom), IPS pilots that target individuals with mild-to-moderate mental health conditions are currently being implemented. The iCAN Work pilot in Wales was launched in 2019 and targeted individuals who have worked for some time within the past 12 months and who are actively seeking work. The pilot was extended amidst the COVID-19 crisis, and the Welsh government has committed to publishing an evaluation of the pilot.

The next step is to scale up the small number of promising examples to provide more widespread and timely access to treatment. While evidence on the effectiveness of IPS remains strongest for participants experiencing severe mental health conditions, these examples show that many OECD countries would also benefit from expanding access to IPS to individuals experiencing mild-to-moderate mental health conditions. The relative lack of promising recent examples of individualised support for this group within the social protection system also indicates a concerning trend – that employment services and social benefits may still approach employment support as only necessary once individuals have been "treated and cured" for their mental health conditions. Such an approach, if still widespread, overlooks that meaningful employment is often a crucial element of treatment and recovery.

Workers in the social protection system are increasingly trained in mental health awareness, but policies need to go beyond disability services

A number of countries – such as Australia, the Czech Republic, Latvia, Lithuania, New Zealand and Switzerland – have put in place measures to provide mental health training to staff in employment services and social benefit offices. However, much like all other mental health policies in the social protection system, initiatives are primarily geared towards individuals on disability benefits. Unlike in schools, workplaces and health systems, the front-line actors in social protection systems tend to be more diverse as individuals with mental health conditions are often connected to different parts of the system. Given that individuals experiencing mental health conditions receive a range of income-support payments and benefits as shown in this report, ensuring mental health literacy and competence across the different parts of the social protection system, including among caseworkers administering unemployment benefits, remains crucial going forward.

For example, in Latvia, a framework is being implemented to train municipal social service workers who work with adults with disabilities related to mental health conditions. By 2023, it is expected that up to 180 social workers will have participated in an intensive six-month training programme focused on providing

support for adults with intellectual disabilities and experiencing mental health conditions. Meanwhile, in Australia, starting in July 2020, the National Disability Insurance Scheme has made support from psychosocial recovery coaches available for participants with psychosocial disabilities. The role of the recovery coach is to support participants in living a fuller and contributing life, including through supporting linkages with broader services including employment and education (NDIS, 2020[32]).

References

Anthes, E. (2016), “Pocket psychiatry: mobile mental-health apps have exploded onto the market, but few have been thoroughly tested”, *Nature*, Vol. 532/7597, pp. 20-24. [13]

Australian Government (2021), *The National Children’s Mental Health and Wellbeing Strategy*, https://www.mentalhealthcommission.gov.au/getmedia/e369a330-f8c3-4b9e-ab76-7a428f9ff0e3/national-childrens-mental-health-and-wellbeing-strategy-report-25oct2021 (accessed on 18 October 2021). [6]

Australian Government Department of Health (2019), *Prioritising Mental Health – national headspace network*, https://www.health.gov.au/sites/default/files/prioritising-mental-health-national-headspace-network_0.pdf (accessed on 25 February 2021). [24]

Browne, J. et al. (2018), “Faces of Joblessness in Estonia: A People-centred perspective on employment barriers and policies”*, OECD Social, Employment and Migration Working Papers*, No. 206, OECD Publishing, Paris, https://dx.doi.org/10.1787/6d9cd656-en. [29]

Department for Work and Pensions and Department for Health and Social Care (2017), *Improving Lives The Future of Work, Health and Disability*, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/663399/improving-lives-the-future-of-work-health-and-disability.PDF (accessed on 16 September 2020). [18]

Eurostat (2021), *Early leavers from education and training*, https://ec.europa.eu/eurostat/databrowser/view/t2020_40/default/table?lang=en (accessed on 24 February 2021). [23]

Government of Ireland (2019), *Part II-Expenditure Allocations 2019-21*, http://www.budget.gov.ie/Budgets/2020/Documents/Budget/Estimates%20of%20Receipts%20and%20Expen (accessed on 24 February 2021). [21]

HM Government (2019), *Health is everyone’s business: Proposals to reduce ill health-related job loss*. [8]

Independent Mental Health Taskforce to the NHS in England (2016), *The Five Year Forward View for Mental Health*, https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf (accessed on 28 June 2020). [3]

KPMG (2020), *Report on the value for money of the IPS Trial - for the Department of Social Services*, https://www.pc.gov.au/inquiries/completed/mental-health/draft. [31]

KPMG (2019), *Final Report for the Evaluation of the Individual Placement and Support Trial - Department for Social Services*, https://www.dss.gov.au/sites/default/files/documents/08_2019/individual-placement-and-support-trial-evaluation-report-june-2019.pdf (accessed on 9 September 2020). [30]

Loveless, L. (2019), *Employment Advisers in Improving Access to Psychological Therapies: Process Evaluation Report*, ICF International, https://www.gov.uk/government/collections/research-reports (accessed on 16 September 2020). [19]

Mazza, D. et al. (2019), *Technical Report for the Clinical practice guideline for the diagnosis and management of work-related mental health conditions in general practice*, Monash University, Melbourne, https://www.monash.edu/__data/assets/pdf_file/0006/1696695/Guideline-Technical-Report.pdf (accessed on 18 October 2021). [15]

Mental Health Services in the Capital Region of Denmark (2020), *IBBIS*, https://www.psykiatri-regionh.dk/Kvalitet-og-udvikling/udvikling/ibbis/Sider/default.aspx (accessed on 3 September 2020). [28]

MHLW (2019), *2018 Stress check seido no jisshi joukyou (Implementation of stress check system)*, https://www.mhlw.go.jp/content/11303000/000582829.pdf (accessed on 25 August 2020). [25]

NDIS (2020), *Mental health and the NDIS*, https://www.ndis.gov.au/understanding/how-ndis-works/mental-health-and-ndis (accessed on 3 September 2020). [32]

New Zealand Treasury (2019), *The Wellbeing Budget*, https://treasury.govt.nz/sites/default/files/2019-05/b19-wellbeing-budget.pdf (accessed on 2 September 2020). [9]

NHS (2020), *Apps Library: National Health Service*, https://www.nhs.uk/apps-library/ (accessed on 2 June 2020). [14]

Nieuwenhuijsen, K. et al. (2020), “Interventions to improve return to work in depressed people”, *Cochrane Database of Systematic Reviews*, http://dx.doi.org/10.1002/14651858.cd006237.pub4. [27]

Octopus Group (2020), *Global investment in mental health technology surges above half a billion pounds*, https://octopusgroup.com/newsroom/latest-news/global-investment-in-mental-health-technology-surges-above-half-a-billion-pounds/ (accessed on 18 September 2020). [12]

OECD (2021), *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Ill-Health*, OECD Health Policy Studies, OECD Publishing, Paris, https://dx.doi.org/10.1787/4ed890f6-en. [4]

OECD (2021), *Report on the Implementation of the Recommendation of the Council on Integrated Mental Health, Skills and Work Policy*, https://one.oecd.org/document/C/MIN(2021)19/en/pdf. [2]

OECD (2020), *OECD Mental Health Performance Benchmarking Data and Policy Questionnaires*, OECD, Paris. [1]

OECD (2020), *Waiting Times for Health Services: Next in Line*, OECD Health Policy Studies, OECD Publishing, Paris, https://dx.doi.org/10.1787/242e3c8c-en. [16]

OECD (2015), *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work*, Mental Health and Work, OECD Publishing, Paris, https://dx.doi.org/10.1787/9789264228283-en. [17]

Psycom (2020), *Map of actors producing online content on mental health issues*, https://www.psycom.org/wp-content/uploads/2020/10/Cartographie-PSYCOM-2020_small.pdf (accessed on 24 February 2021). [10]

SAMHSA (2020), *Project AWARE (Advancing Wellness and Resiliency in Education) State Education Agency Grants | SAMHSA*, https://www.samhsa.gov/grants/grant-announcements/sm-20-016 (accessed on 3 September 2020). [22]

Seland, I. et al. (2020), *Evaluering av ordning med fylkesvise mobbeombud for barnehage og grunnskole [Evaluation of a national anti-bullying ombudsmen scheme for kindergarten and primary school]*, Oslo Metropolitan University, http://www.oslomet.no/om/nova (accessed on 25 February 2021). [20]

Shatkin, J. and M. Belfer (2004), "The Global Absence of Child and Adolescent Mental Health Policy", *Child and Adolescent Mental Health*, Vol. 9/3, pp. 104-108, http://dx.doi.org/10.1111/j.1475-3588.2004.00090.x. [5]

Swedish Ministry of Health and Social Affairs (2019), *För att börja med något nytt måste man sluta med något gammalt: Förslag för en långsiktigt hållbar styrning inom området psykisk hälsa [Proposals for long-term sustainable governance in the field of mental health]*. [7]

Time to Change (2021), *Impact report 2016-21*, https://time-to-change.turtl.co/story/impact-report-2016-21/ (accessed on 3 October 2021). [11]

UK Government (2017), *Thriving at work: The Stevenson/Farmer review of mental health and employers*. [26]

Notes

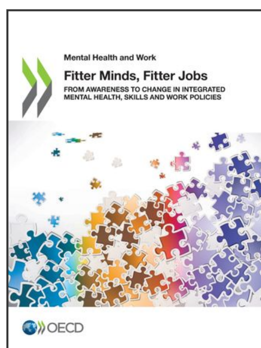
[1] Only five OECD countries (Canada, France, Germany, Norway and the United Kingdom) reported spending more than 10% of their health spending on mental health.

[2] GBP 120 million in 2014 to GBP 580 million in 2019.

[3] These OECD countries are Denmark, Finland, Ireland, Lithuania, the Netherlands, New Zealand, Norway, Spain (specific regions), Sweden and the United Kingdom.

[4] WHU was set up in 2015 as a joint unit of the Department for Work and Pensions and Department of Health and Social Care.

[5] Although this concerns reform of the social protection system, the policy is about getting individuals who are on sick leave – technically still in employment – back into work and is thus included in the workplace section of the Recommendation. By comparison, reforms targeted at individuals who are already out of work and seeking employment are covered in the social benefits and employment services section of the Recommendation.



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