Chapter 1

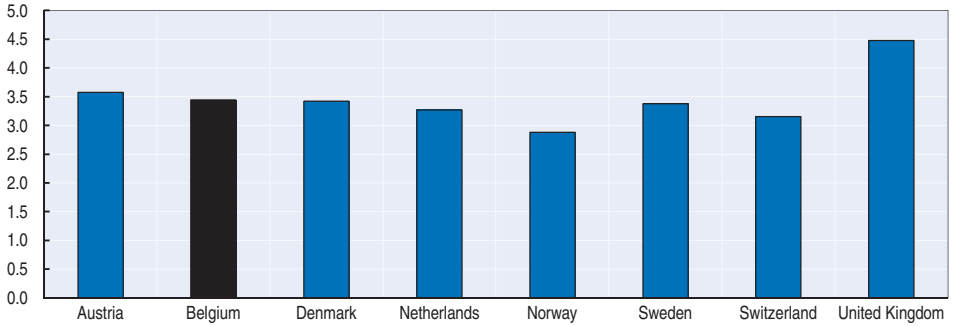
Mental health and work challenges in Belgium

Building on the findings in the recently published OECD report Sick on the Job?*, this chapter highlights the key challenges in the area of mental health and work and provides an overview of the current labour market performance of people with a mental disorder in Belgium compared to other OECD countries in terms of their employment and unemployment state, as well as their financial situation. The chapter also describes the role of the different government layers and the Belgian benefit system. It ends with a discussion of the advantages and challenges of the prominent role of the unemployment benefit system for people with a mental disorder in Belgium.*

Mental ill-health poses important challenges for the well-functioning of labour markets and social policies in OECD countries. These challenges have not been addressed adequately so far, reflecting widespread stigma and taboos. The total (direct and indirect) estimated costs of mental ill-health for society are large, reaching 3-4.5% of GDP across a range of selected OECD countries; 3.4% in Belgium (Figure 1.1).[1] Most of these costs do not occur within the health sector: indirect costs in the form of lost employment and reduced performance and productivity on-the-job are much higher than the direct healthcare costs. Based on comprehensive cost estimates in Gustavsson *et al.* (2011), indirect costs, direct medical costs and direct non-medical costs amount to 53%, 36% and 11%, respectively, of the total costs of mental disorders for society.

Figure 1.1. **Mental disorders are very costly to the society**

Costs of mental disorders as a percentage of the country's GDP, 2010



Note: Costs estimates in this study were prepared on a disease-by-disease basis, covering all major mental disorders as well as brain disorders. This chart includes mental disorders only.

Source: OECD compilation based on Gustavsson, A., M. Svensson, F. Jacobi *et al.* (2011), "Cost of Disorders of the Brain in Europe 2010", *European Neuropsychopharmacology*, Vol. 21, pp. 718-779 for cost estimates, and Eurostat for GDP.

Introduction

According to the recently published OECD report *Sick on the Job? Myths and Realities about Mental and Work*, policy needs to respond more effectively to the challenges for improving the labour market inclusion of people with mental illness (OECD, 2012). More attention will need to be given to: mild and moderate mental disorders; disorders concerning the employed and the unemployed; and proactive measures to help them remain in work or find a job. This conclusion is drawn on the basis of a number of findings, including:

- Most people with a mental disorder are in work.

- Many people with a mental disorder want to work.
- Productivity losses at work through mental ill-health are large.
- People on unemployment or social assistance benefits often suffer from mental ill-health.
- Mental ill-health accounts for an increasing share of work incapacity, sickness and disability.
- Appropriate treatment can improve employment outcomes but under-treatment is pervasive.

Mental disorder in this report is defined as mental illness reaching the clinical threshold of a diagnosis according to psychiatric classification systems like the International Classification of Diseases (ICD-10) which is in use since the mid-1990s (ICD-11 is currently in preparation). Thus defined, at any one moment some 20% of the working-age population in the average OECD country is suffering from a mental disorder, with lifetime prevalence reaching up to 40-50% (see Box 1.1).

Understanding the characteristics of mental ill-health is critical for devising the right policies. The key attributes of a mental disorder are: an early age at onset; its severity; its persistence and chronicity; a high rate of recurrence; and a frequent co-existence with physical or other mental illnesses. The more severe, persistent and co-morbid the illness, the greater is the degree of disability associated with the mental disorder and the potential impact on the work capacity of the person.[2]

A particular challenge for policy makers is the high rate of non-awareness, non-disclosure and non-identification of mental disorders – directly linked with the stigma attached to mental illness. However, it is not clear in all cases whether more and earlier identification would always improve outcomes or, instead, may contribute to labelling and the risk of stigmatisation. This implies that reaching people with a mental disorder is more important than labelling them and policies that avoid labelling might sometimes work best.

Sick on the Job? identifies two key directions for reform. First, policies should move towards preventing problems, identifying needs and intervening at various stages of the lifecycle, including during the transition into work, at the workplace, and when people are about to lose their job or to move into the benefit system. Second, steps should be taken towards integrating (or at least better co-ordinate) health, employment and, where necessary, other social services to combat such problems among people with mental ill-health.

Box 1.1. **The measurement of mental disorders**

Administrative data (*e.g.* clinical data and data on disability benefit recipients) generally include a classification code on the diagnosis of a patient or recipient, based on ICD-10. In such case, data measuring the existence of a mental disorder are readily available. This is also the case in Belgium. These administrative data do not include detailed social and economic variables necessary to assess labour market outcomes, however, and they also cover only a fraction of all the people with a mental disorder.

Survey data with sufficient information on socio-economic variables, on the contrary, in most cases only include subjective information on the mental health status of the sample population. The existence of a mental disorder can be measured in such surveys through a mental health instrument, which consists of a set of questions on irritability, nervousness, sleeplessness, hopelessness, happiness, worthlessness, and so on. Such instruments allow the identification of people in good and poor mental health. For the OECD review on *Mental Health and Work*, the 20% of the population with the highest values on the respective instrument is classified as having a mental disorder in a clinical sense, with those 5% with the highest value categorised as "severe" and the remaining 15% as "mild and moderate" or "common" mental disorder.

This methodology allows comparisons across different mental health instruments used in different surveys and countries. See OECD (2012) and *www.oecd.org/els/disability* for a more detailed description and justification of this approach (the aim of which is to measure the social and labour market outcomes of people with a mental disorder, not the prevalence of mental disorders as such), as well as the possible implications.

For Belgium, data from three different surveys are used in this report: 1) The *Belgian Health Interview Survey* of 1997, 2001 and 2008; the mental-disorder variable is based on the GHQ-12 General Health Questionnaire, a screening tool for non-psychotic psychiatric disorders and a shorter version of the full GHQ-60 scale. 2) The *Eurobarometer* for 2005 and 2010: the mental disorder variable is based on a set of nine items: feeling full of life, feeling tense, feeling down, feeling calm and peaceful, having lots of energy, feeling downhearted and depressed, feeling worn out, feeling happy, feeling tired. 3) The *European Working Conditions Survey* (EWCS) for 2010: the mental disorder variable is based on a set of five items: feeling cheerful; feeling calm; feeling active; waking up fresh and rested; life fulfilling.

Notwithstanding the evident major costs of poor mental health, policies and institutions are not addressing mental ill-health sufficiently. Four core priority areas are identified in the report, which need urgent policy attention to minimise the serious adverse consequences of mental ill-health in the society. These include:

- *The importance of schools* to protect and promote the mental health of children and young people and of transition services to help vulnerable youth access the labour market successfully.

- *The importance of workplaces* to protect and promote mental health in order to prevent illness, reduced productivity at work and labour market exit.
- *The importance of employment services* for beneficiaries of long-term sickness, disability and unemployment benefits who are not working.
- *The importance of psychiatric services* delivered in ways that assist people of working age to either remain in work or to return to work.

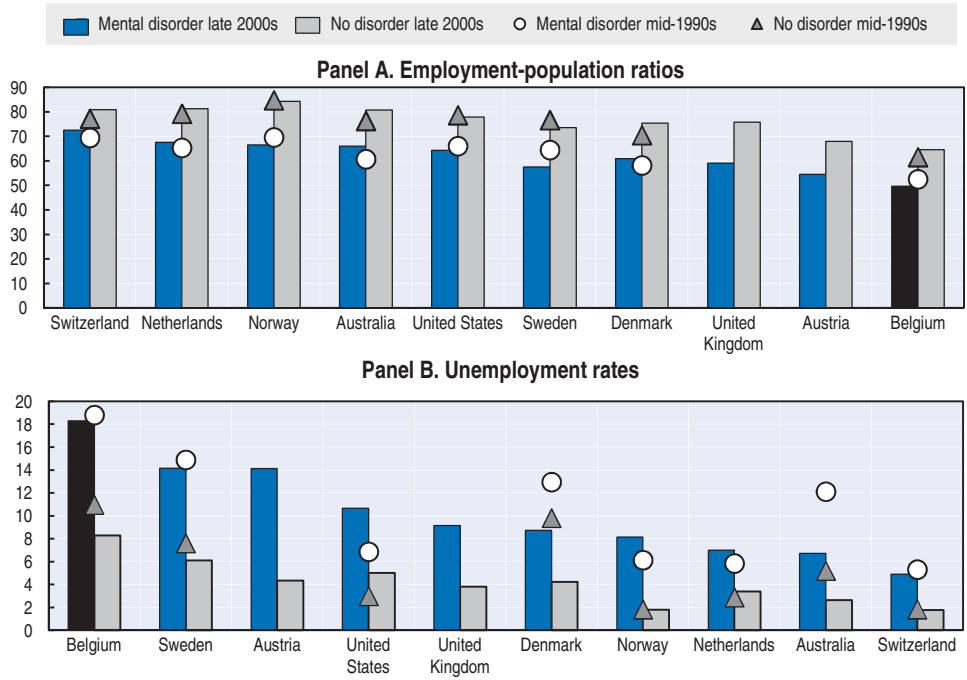
In the context of these challenges and priority areas for policy actions, the purpose of this report is to examine how policies and institutions in Belgium are addressing issues of mental ill-health and employment.

The structure of this report is as follows. The remaining sections of this chapter set the scene by: *i)* looking at some of the key outcomes for people with a mental disorder in Belgium; *ii)* discussing the responsibility of different government layers – *i.e.* federal, community and region – in regard to education, social, employment and mental health policies; and *iii)* describing the main systems catering for people with mental illness, especially the sickness and disability system and the public employment services. The other chapters of the report analyse the 'mental health and work' policy challenges that Belgium is facing by taking a life-cycle perspective. Chapter 2 looks at the period before a young person enters the labour market, *i.e.* the school and education system and the transition into the labour market. Chapter 3 analyses what is happening in the workplace and under the responsibility of the employer. Chapter 4 discusses the role of the different stakeholders of the sickness and disability benefit system, while Chapter 5 looks at the disability allowance system. Chapter 6 evaluates the unemployment benefit system and the final chapter, Chapter 7, discusses the role and contribution of the mental health system in each of these different phases.

Key trends and outcomes

As is the case in other OECD countries, people with a mental disorder in Belgium are less likely to be employed than people without mental health problems, with the employment rates being 50% and 65%, respectively (Figure 1.2, Panel A). Despite the general labour market improvement prior to the onset of the Great Recession in 2008, the employment rate of people with mental disorders in Belgium declined between 1997 and 2008, resulting in an increase in the employment gap compared with those without mental health problems from 9 to 15 percentage points (no data by mental health status are available for the post-2008 period).

Figure 1.2. **Labour market outcomes improved before the Great Recession in Belgium, except for people with a mental disorder, mid-1990s and late 2000s**



Source: OECD calculations based on national health surveys. Australia: National Health Survey 2001 and 2007/08; Austria: Health Interview Survey 2006/07; Belgium: Health Interview Survey 1997 and 2008; Denmark: National Health Interview Survey 1994 and 2005; Netherlands: POLS Health Survey 2001/03 and 2007/09; Norway: Level of Living and Health Survey 1998 and 2008; Sweden: Living Conditions Survey 1994/95 and 2009/10; Switzerland: Health Survey 2002 and 2007; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: National Health Interview Survey 1997 and 2008.

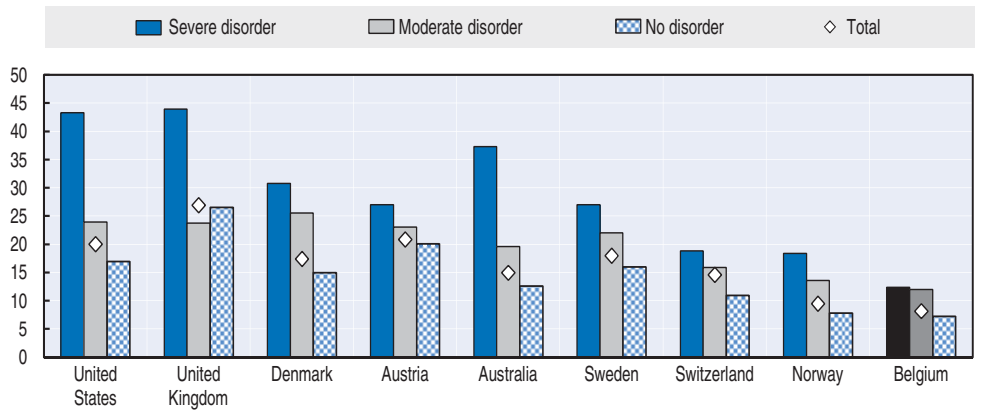
Unemployment rates for people with mental ill-health across OECD countries are consistently two to three times higher than for those without a mental disorder (Figure 1.2, Panel B). In Belgium, the unemployment rate for people with mental disorders reached 18% in 2008, compared with 8% for those without a mental disorder (no data by mental health status are available for the post-2008 period). Many people with mental disorders would thus like to work, but have difficulties in finding or retaining a job.

As a result of their under-performance in the labour market, people with a mental disorder are at a higher risk of relative income poverty than the average population. About 12% of people with severe or moderate mental disorders live in households with incomes below the poverty threshold, compared with 7% for their counterparts without mental health problems (Figure 1.3). Nevertheless, both the overall poverty risk and the difference in

poverty risks by mental health status are quite low in Belgium compared with other OECD countries.

Figure 1.3. **People with a mental disorder have a larger poverty risk**

Poverty risks[a] for people with a severe, moderate or no mental disorder, latest year available

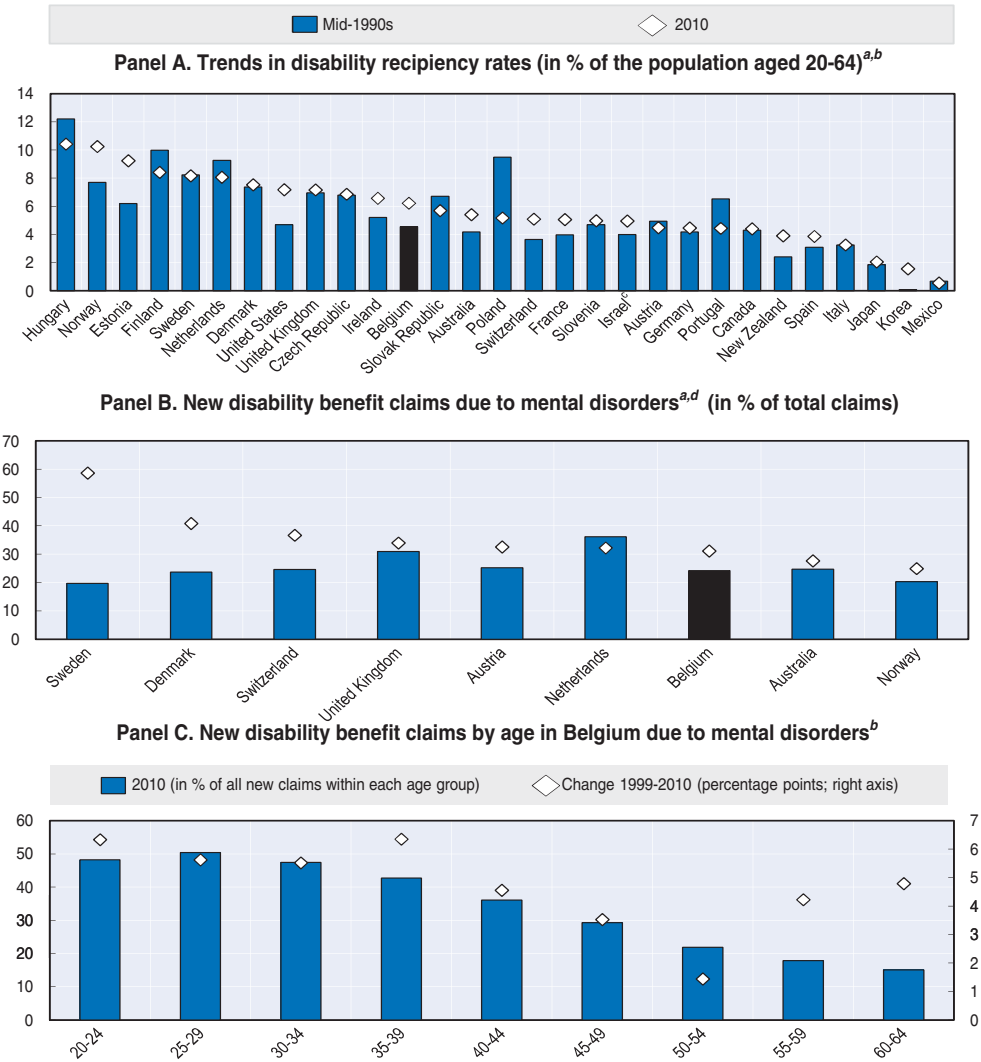


a. The percentage of people living in households with incomes below the low-income threshold (defined as 60% of median income).

Source: OECD calculations based on national health surveys. Australia: National Health Survey 2007/08; Austria: Health Interview Survey 2006/07; Belgium: Health Interview Survey 2008; Denmark: National Health Interview Survey 2005; Netherlands: POLS Health Survey 2007/09; Norway: Level of Living and Health Survey 2008; Sweden: Living Conditions Survey 2009/10; Switzerland: Health Survey 2007; United Kingdom: Health Survey of England 2006; United States: National Health Interview Survey 2008..

At the same time, the absolute number of disability recipients and the share of mental disorders among new disability benefit claims are both increasing rapidly. By the late 2000s, 6.2% of the population aged 20-64 in Belgium was receiving sickness or disability benefits, up from 4.6% in the mid-1990s (Figure 1.4, Panel A). The increase in disability benefit claims in Belgium is to a large extent due to the increase in the pension age for women from 60 in 1997 to 65 in 2009 (Jousten *et al.*, 2011). Yet, more importantly and in line with trends in many OECD countries, an increasing share of new disability benefit claims are related to mental ill-health, reaching nearly one third of all new claims in 2010 in Belgium (Figure 1.4, Panel B). Worryingly, the increase is largest among younger people (aged 20-39 years), where the share of mental health problems among new claims within that age group attained nearly 50% in 2010 compared with about 20% among the age group 50-64 (Figure 1.4, Panel C).

Figure 1.4. **Fast increase in disability benefit claims due to mental disorders**



a. Norway includes the temporary benefit in Panel A, but not in Panel B.

b. Data refer to 2005 for Luxembourg, to 2007 for Canada, France, Italy and Poland, to 2008 for Australia, Austria, Japan, Korea and Slovenia and to 2009 for Germany, Mexico, New Zealand, Norway, the Slovak Republic, the United Kingdom and the United States.

c. Information on data for Israel: *http://dx.doi.org/10.1787/888932315602*.

d. Belgium, the Netherlands and Sweden include mental retardation, organic and unspecified disorders.

Source: OECD questionnaire on disability and OECD questionnaire on mental health.

Despite the increasing disability due to mental disorders, there is ample epidemiological and clinical empirical evidence that the prevalence of mental disorders has not increased in OECD countries. The recently published OECD report *Sick on the Job?* (OECD, 2012) concludes that the shift in the structure of new disability claims towards mental disorders is partly the consequence of a better awareness of such disorders and the often false interpretation that such disorders would cause high and permanent work incapacity. At the same time, job requirements in the workplace have increased or changed, making it increasingly difficult for workers with mental health problems to perform adequately.

Description of the social protection system in Belgium

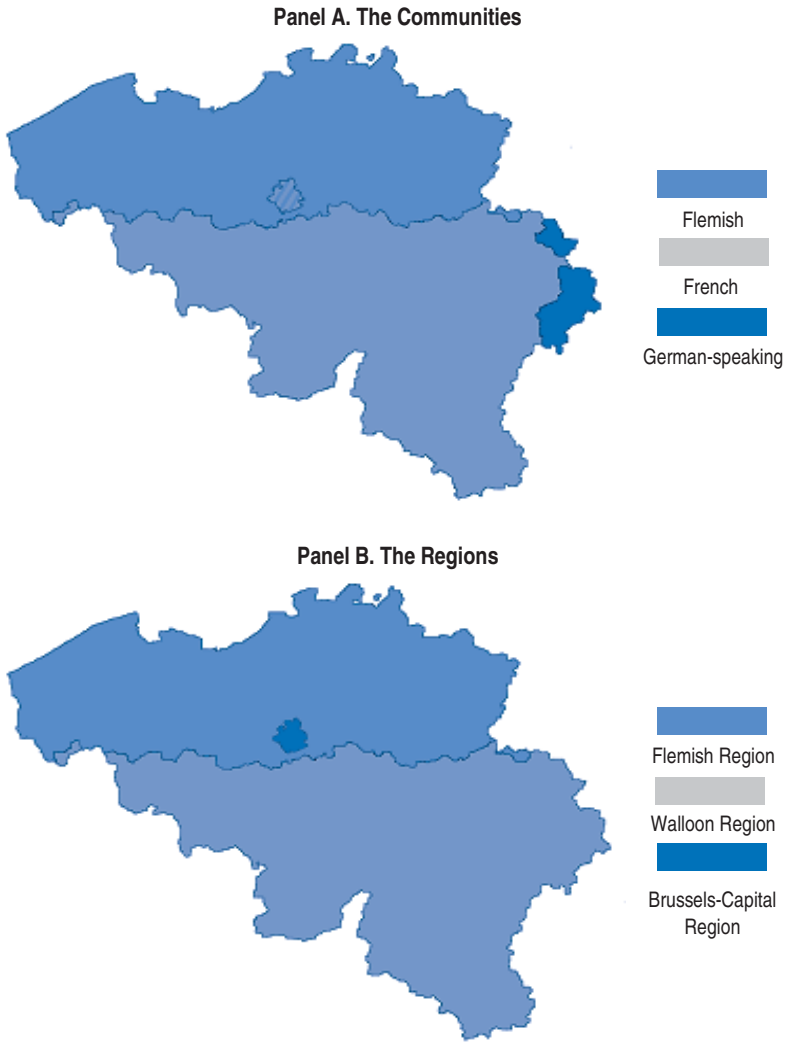
The structure of the federal state

Belgium is a federal state composed of three Communities, *i.e.* the Flemish Community, the French Community and the German-speaking Community (Figure 1.5, Panel A), and three Regions, *i.e.* the Brussels-Capital Region, which is officially bilingual, the Flemish Region, which is Dutch-speaking, and the Walloon Region, which is French and German-speaking (Figure 1.5, Panel B).

The main federal institutions are the federal government and the federal parliament (with a Chamber of Representatives and a Senate), while the Communities and Regions each have their own government and parliament. Yet, the Flemish Region transferred all its constitutional competences to Flemish Community immediately after its establishment in 1980, to facilitate the co-operation between the departments responsible for community and regional matters. There is thus only one government and one parliament in Flanders.

The three language Communities enjoy powers over various policy areas, such as family and child support, education, culture, and certain aspects of health care. The three Regions focus primarily on considerations of an economic or local nature such as employment, public works, agriculture, land-use planning and the environment. The sixth institutional reform of 2011 (to be implemented after 2014) involves a further decentralisation of resources and policies to the Regions and Communities, which are assigned more decision-making powers in the areas of labour market, family benefits and others (issues relevant for this report will be discussed in the respective sections). Social security, on the other hand, remains a core activity of the federal level. The details and exact implementation of the latest reform are still under discussion.

Figure 1.5. **The structure of the federal state Belgium**



Note: This map is for illustrative purposes and is without prejudice to the status of or sovereignty over any territory covered by this map.

Source: Adapted from wikipedia, *http://en.wikipedia.org/wiki/Communities,_regions_and_language_areas_of_Belgium*.

Social protection in Belgium

Social protection in Belgium can be classified into two broad categories: *i) social security*, *i.e.* medical care, sickness and disability insurance benefits, pensions, unemployment insurance, family benefits, work accidents insurance, professional diseases insurance, and annual vacation; and *ii) social assistance*, *i.e.* integration income, guaranteed income for the elderly, disability allowances and guaranteed family allowances. Within the social security system, three broad regimes for wage-earners, self-employed and civil servants can be distinguished, with substantial differences in coverage and the degree of social protection. A discussion of the social insurance systems for the self-employed and civil servants is beyond the scope of this report; the reader is referred to the overview of Belgian social security published by the Federal Public Service for Social Security (2011) for more details.

Public health insurance is organised and co-rdinated at the federal level by the National Institute for Sickness and Invalidity Insurance (RIZIV/INAMI). Unlike in most other OECD countries, the same institution is responsible for both sickness benefits (up to one year) and disability benefits (beyond one year), and all disability beneficiaries necessarily go through one year of sickness benefits (see Box 1.2 for an overview of the eligibility conditions and benefit levels). At the operational level, the National Institute for Sickness and Invalidity Insurance relies on a series of accredited mutual insurance providers that act as the interface between the health insurance system and the insured – with financial balancing mechanisms in place for compensating inherently different risk pools between providers. Beyond their role as paying agents on behalf of the National Institute for Sickness and Invalidity Insurance, the mutualities are also the key gatekeepers in the access to sickness and disability benefits.

Besides the sickness and disability benefits paid by the National Institute for Sickness and Invalidity Insurance, disabled people with a reduced earning capacity are eligible for two types of non-contributory disability allowances of the Federal Public Service for Social Security (see Box 1.2 for the benefit levels and eligibility criteria). The "income replacement allowance" is mainly for people who have never worked or not long enough to fulfil the disability insurance contributory requirements, but can also be paid on top of other working-age benefits if the household income is below a certain threshold. The "integration allowance" compensates people for the additional difficulties they encounter in daily activities due to their disability. Both types of disability allowances are granted independently of each other and can be combined with other benefits.

The payment of unemployment benefits is organised at the federal level by the National Employment Office (RVA/ONEM), while the job placement and active labour market policies are fully in the hands of the regional public employment services – VDAB (*Vlaamse Dienst voor Arbeidsbemiddeling en Beroepsopleiding*) in Flanders, Actiris in Brussels and Forem in Wallonia) – requiring an important need for co-ordination. In addition, trade unions play an important operational role as official paying agents for their members, while non-unionised unemployed people receive their benefits from yet another public institution, *i.e.* the Auxiliary Fund for the Payment of Unemployment Benefits. Benefits are computed based on capped past earnings and have similar initial payment rates as disability benefits (see Box 1.2.), and they are payable indefinitely. Continued receipt of unemployment benefits is dependent on meeting job-search and availability conditions; these conditions, however, were not universally applicable to all beneficiaries (*e.g.* unemployed people older than 50 were exempted from such requirements until end-2011).

Box 1.2. **Eligibility conditions and benefit rates for selected Belgian benefit schemes**

Unemployment benefits

To be entitled to unemployment benefits, a job seeker must have worked for more than a year during 27 months – the employment requirement increases with age, *e.g.* a worker aged 36-49 years must have worked 468 days during 27 months – and people who become voluntarily unemployed can be temporarily excluded from receiving benefits for a period of 4-52 weeks. Eligibility is not entirely based on a contributory history, as high-school graduates can enter the unemployment rolls without ever having contributed to the system. The waiting periods for graduates are 155, 233 and 310 days for the age groups under 18, 18-25 and 26-29 respectively.

Sickness and disability insurances

To be eligible for sickness and disability benefits, a wage earner must have worked at least 120 days (paid vacation and sickness leave are counted as actual work) during a period of six months prior to obtaining benefits and must satisfy minimum contributory requirements. A medical-economic definition determines eligibility for sickness and disability benefits: a worker has to suffer from a loss of earnings capacity of 66% or more as a result of injuries or functional difficulties, or aggravation of these. Any job a person did, or could possibly do according to his/her qualifications and experience, is considered. However, if the illness shows a favourable evolution, only the usual occupation is taken into account during the first six months to determine the earnings capacity loss.

Box 1.2. **Eligibility conditions and benefit rates for selected Belgian benefit schemes** *(cont'd)*

Disability allowances

Income replacement allowances and integration allowances are non-contributory benefits for disabled people. A person is entitled to income replacement allowances if he/she is unable to earn more than one third of what a healthy person can earn by working. The integration allowance is determined by the reduction of autonomy as a result of the disability, which is evaluated using a medical-social scale. Both disability allowances are means-tested and depend on the family situation. The income replacement allowance and integration allowance can be granted together or separately, and can be combined with other benefits.

Benefit rates and maximum benefit levels, 2011

	Person with dependants[a]	Single person[b]	Cohabitant[c]
	Benefit rates in percentage of previous earnings		
Unemployment benefit			
1st year	60	60	60
2nd year (first three months)	60	55	40
after first three months of 2nd year	60	55	lump sum[d]
Sickness and disability insurance			
Sickness benefit	60	60	60
Disability benefit	65	60	40
	Maximum benefit amounts per month (EUR)		
Disability allowance			
Income replacement allowance	1007	755	504
(as a % of the average wage)	(30%)	(22%)	(15%)
Integration allowance	828	828	828
(as a % of the average wage)	(25%)	(25%)	(25%)

a. A worker who lives with one or more persons who do not have a professional or alternative income.

b. A worker who lives alone.

c. Worker who neither lives alone nor has dependents; cohabitants are people who live together in the same household and share common household issues.

d. The lump-sum allowance was EUR 465 per month on 1 July 2011 (equal to about 14% of the average wage). If the recipient has completed 20 years of professional service or has 33% of permanent unemployability, the benefit rate is 40% of previous earnings. In addition, under certain conditions, a cohabitant can see his unemployment benefit suspended if the duration of unemployment exceeds 1.5 times the regional average for his age group and gender.

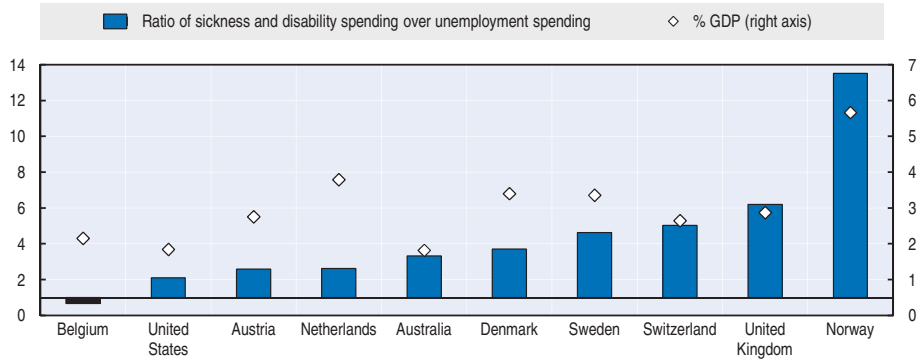
Source: Belgium 2010, Benefits and Wages: OECD Indicators, www.oecd.org/els/social/workincentives, and the Belgian National Institute for Sickness and Invalidity Insurance.

The importance of the unemployment benefit system for people with a mental disorder

Not all people with a mental disorder who are unable to find a job end up on disability benefits; many are dependent on other types of working-age benefits, such as unemployment benefits or social assistance. In contrast to most other OECD countries, the overall expenditure on disability and sickness in Belgium is lower than spending on unemployment, (Figure 1.6; see Appendix for more detailed statistics on all OECD countries). There are also more people with a moderate mental disorder on unemployment benefits in Belgium than there are on disability benefits and a relatively large share of those with a severe mental disorder receives unemployment benefits, while this group would typically receive disability benefits in other OECD countries (Figure 1.7).

Figure 1.6. **Belgium spends less on disability and sickness than on unemployment**

Expenditure on disability and sickness in percentage of GDP and as a ratio of unemployment spending, 2009



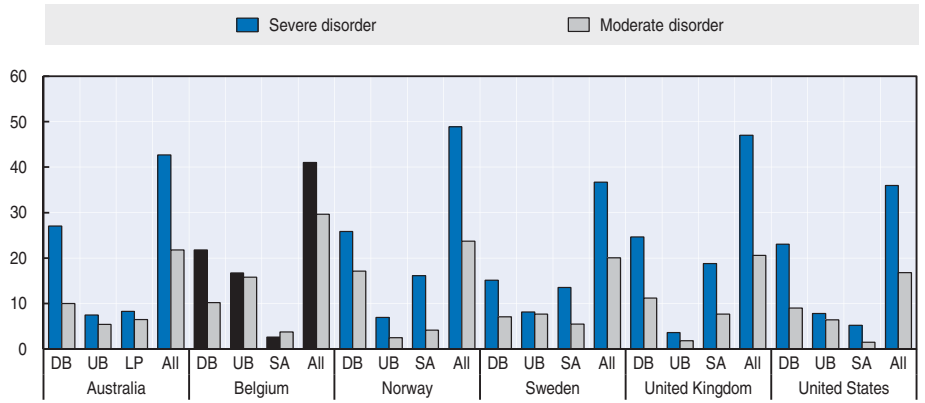
Source: *OECD Social Expenditure Database (SOCX), www.oecd.org/els/social/expenditure.*

The prominent role of the unemployment benefit system for people with a mental disorder in Belgium is related to a number of factors. First, the time-unlimited unemployment benefit system renders the more stringent disability benefit system less attractive to people with mental ill-health. Unemployment beneficiaries have the obligation to actively look for a job and can be suspended if they do not co-operate, but mental ill-health is a valid reason for refusing suitable job offers and caseworkers often find it socially unacceptable to suspend long-term beneficiaries with multiple problems (among which often mental health problems) whom they cannot activate (see Chapter 6 for a discussion). Not all unemployed people with mental health problems are eligible for disability benefits (in particular those with moderate mental disorders) and even if they are, the transfer onto

disability benefits is long and people may temporarily end up without benefits. Second, disability beneficiaries are regularly controlled for health improvements (with the frequency decided by the mutuality doctor, see Chapter 4 for a discussion), while this is not necessarily the case in the unemployment benefit system. As such, people with a mental disorder may actually perceive the unemployment benefit system as more permanent and secure than the disability benefit system. Third, there are no strong financial incentives for unemployment beneficiaries with (mental) health problems to apply for a sickness and disability benefit as the benefit levels are more or less comparable (see Box 1.2 above). Nevertheless, since November 2012, unemployment benefits have become more degressive and less generous than disability benefits and may give people with health problems more incentives to apply for sickness and disability benefits.

Figure 1.7. **Many people with a mental disorder receive unemployment benefits in Belgium**

Proportion of people receiving a disability benefit (DB), unemployment benefit (UB), social assistance payment (SA) or lone-parent benefit (LP), by mental health status, distribution in the latest year available



Note: Disability benefit includes a variety of incapacity-related benefits. In Belgium, for instance, it includes sickness benefits, disability insurance benefits and disability allowance benefits.

Source: OECD calculations based on national health surveys. Australia: National Health Survey 2007/08; Austria: Health Interview Survey 2006/07; Belgium: Health Interview Survey 2008; Denmark: National Health Interview Survey 2005; Netherlands: POLS Health Survey 2007/09; Norway: Level of Living and Health Survey 2008; Sweden: Living Conditions Survey 2009/10; Switzerland: Health Survey 2007; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: National Health Interview Survey 2008.

The high proportion of people with a mental disorder on unemployment benefits has certain advantages, but also requires more attention to the needs

of this group. On the one hand, people with a mental disorder receiving unemployment benefits remain in close contact with the labour market and can therefore be more easily activated. On the other hand, if public employment centres (PES) have no experience in dealing with mental health problems or do not have the (human) resources to devote more attention to this group of beneficiaries, it is unlikely that they will succeed in activating them. Also, stronger activation pressure by the PES could give people incentives to move onto disability benefits. Close co-operation between the PES and the mutualities will therefore be necessary to improve labour market outcomes of people with mental health problems, an issue which will be discussed in detail in Chapters 4 and 6.

Conclusion

The following key facts emerge from the evidence available:

- Labour market conditions improved since the mid-1990s up to the start of the Great Recession, but not for people with mental health problems.
- The increase in disability benefit claims over the past decades is largely due to an increase in the pension age for women. The share of mental disorders among new disability claims is, however, rising rapidly, especially among beneficiaries aged under 40.
- Sickness and disability benefits are integrated into one single system. Tackling sickness absence early on can thus be a very effective strategy for minimising the inflow into disability benefits.
- The unemployment benefit system plays a prominent role for people with a mental disorder upon job loss. Contrary to most other OECD countries, spending on unemployment is higher than spending on sickness and disability and there are more people with a moderate mental disorder on unemployment benefits than on disability benefits. The advantage is that people with mental health problems losing their job remain closely attached to the labour market.

Notes

1. Mental disorders, as defined in this report, exclude intellectual disabilities which encompass various intellectual deficits, including mental retardation, various specific conditions such as specific learning disability, and problems acquired later in life through brain injuries or neurodegenerative diseases like dementia. Organic mental illnesses are also outside the scope of this report.

2. The diagnosis also matters, but mental illness of any type can be severe, persistent or co-morbid. The majority of mental disorders fall in the category mild or moderate, including especially depression and anxiety disorders.

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