Sick on the Job?
Myths and Realities about Mental Health and Work
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Chapter 6

Summary and Conclusions

This chapter summarises the main findings of the report, including new evidence which questions some of the myths and taboos around mental ill-health and work. People with severe mental disorder are too often too far away from the labour market, and need help to find sustainable employment. The majority of people with common mental disorder, however, are employed but struggling in their jobs. Neither are they receiving any treatment nor any supports in the workplace, thus being at high risk of job loss and permanent labour market exclusion. This implies a need for policy to shift away from severe to common mental disorders and sub-threshold conditions; away from a focus on inactive people to more focus on those employed; and away from reactive to preventive strategies.

6.1. Mental health as a new priority challenge for the labour market

The costs of mental ill-health for the individuals concerned, employers and society at large are enormous. A conservative estimate from the International Labour Organisation put them at 3-4% of gross domestic product in the European Union. Most of these costs do not occur within the health sector. Mental illness is responsible for a very significant loss of potential labour supply, high rates of unemployment, and a high incidence of sickness absence and reduced productivity at work. In particular, mental illness causes too many young people to leave the labour market, or never really enter it, through early moves onto disability benefit. Today, between one-third and one-half of all new disability benefit claims are for reasons of mental ill-health, and among young adults that proportion goes up to over 70%.

Mental ill-health is a difficult issue to analyse. The available evidence on mental illness and its connection with work is partial or incomplete, and many important elements are still unknown or not fully understood. Misconceptions are widespread due to the significant stigma attached to mental illness and a range of fears about people with mental illness in society and at workplaces. This report aims to broaden the evidence base and summarise what is known, and what further information is required, in order to reform policies in ways that will improve the labour market inclusion of people with mental disorders.

Mental ill-health is widespread, but prevalence is not increasing

Mental disorder in this report is defined as mental illness reaching the clinical threshold of a diagnosis according to psychiatric classification systems. Epidemiological and clinical evidence unequivocally shows that the prevalence of mental disorders is high. At any one moment, around 20% of the working-age population in the average OECD country is suffering from a mental disorder in a clinical sense. Typically, prevalence rates are higher for younger adults, women and people with low levels of educational attainment. The 12-month prevalence is even higher and lifetime prevalence has been shown in several studies to reach levels up to 50%. This implies that the risk of experiencing mental ill-health at any moment during working life is high for everyone.

Contrary to widespread beliefs, the prevalence of mental disorder is *not* increasing. There is ample epidemiological and clinical empirical evidence that prevalence has been very high already several decades ago. But because of the gradually reduced stigma and discrimination and greater public awareness of the issue and better means and tools of assessment (including better psychiatric services), more cases of mental disorders are now being identified and disclosed.

The main question then is why mental disorders seem to be associated with greater problems in the labour market than used to be the case, as also shown by increasing rates of disability benefit claims driven by mental disorders. To some extent, it appears that the increased perception of mental health problems has gone hand-in-hand with a changed

view on the work capacity of people with mental disorders, *i.e.* a more work-limiting evaluation of these problems. This would imply that better awareness has so far mostly led to more exclusion from the workforce.

However, at the same time the job requirements in the workplace have increased or changed. Higher requirements on social skills and cognitive competences make it increasingly difficult for workers with mental ill-health to perform adequately. In order to understand these trends better, more needs to be known about the situation of people with mental disorders; the impact of mental disorders on functionality and work capacity; changes in the workplace; the relationship between mental health and work; and the impact of various institutions, systems and policies.

Most mental disorders are moderate or common disorders

Severe mental disorders are relatively rare. Most mental disorders are mild or moderate, frequently referred to as "common mental disorders" (CMD). Mood disorders (depression), neurotic disorders (anxiety) and substance-use disorders are by far the most frequent CMDs. However, any of these illnesses can evolve to become so severe that they would be classified as severe mental disorders (SMD).

Typically, three quarters of those affected by mental disorder have a CMD, and one-quarter a SMD.* The main difference is that CMD is generally less disabling and, thus, less of a problem for the individual concerned and society at large. However, some symptoms of CMD can affect work-related functionality considerably. One of the main challenges for policy makers is therefore to prevent mental health problems at a sub-clinical level from developing into chronic and disabling CMD.

Mental illness commences very early in life

One of the key characteristics of mental disorders is the early onset. The median age at onset across all types of mental disorders is around 14 years of age, with 75% of all illnesses having developed by age 24. Anxiety disorders start particularly early in life and substance-use disorders typically in youth, whereas the first appearance of mood disorders shows a broader distribution across age, with more frequent onset in the thirties and forties.

The early onset of mental illness has several important policy implications. There is considerable lack of awareness, non-disclosure and under-treatment among adolescents and young adults, with the gap before the first treatment of a mental illness on average being about 12 years. Hidden mental disorders at such a young age often have detrimental effects leading to poor performance at school and early school leaving, with negative repercussions in working life.

Chronicity and co-morbidity lead to disability

Many mental disorders are persistent and show high rates of recurrence. For instance, recurrence of depressive episodes varies from 40% to 80%, even with medication. The more chronic a mental disorder, the more disabling it is and the larger are the challenges for labour market inclusion.

* The established epidemiological knowledge that around 5% of the working-age population suffer from SMD and some 15% from CMD is used in this study to identify the target population, on the basis of national and international health surveys which use a range of mental health instruments (see Chapter 1 and especially Box 1.1 for more details).

Similarly, several mental disorders often co-exist, sometimes also with physical health conditions. For example, co-occurrence of depression and anxiety is very frequent, as is the co-occurrence of a substance-use disorder with other health conditions. Again, co-morbid mental disorders tend to be the more disabling ones; for instance, US data from the National Health Interview Survey suggest that the likelihood of being inactive and receiving a benefit is substantially higher with a co-morbid CMD than with a SMD alone (the rates are 45% and 35%, respectively, and 75% for a co-morbid SMD).

Policy will have to put more focus on moderate mental disorders

Because of its high prevalence, the overall cost of CMD to society is larger than the cost of SMD – taking into account all costs for the health system, the social security system and the employers. Similarly, the cost of sub-threshold conditions, because of the even higher prevalence in the population, is potentially very high, as some studies demonstrate. This is explained by the fact that direct health-system costs are only a very small part of the total costs of mental illness, much lower than, in particular, the costs of productivity losses.

This observation alone has significant relevance for policy makers. Policy today predominantly targets people with SMD. This is understandable given the strong and urgent needs of people suffering from SMD and limited public resources. However, in order to deal with mental disorders more effectively greater focus should be devoted to CMD, which when becoming long-lasting or recurrent can manifest themselves in substantial impairments with negative repercussions on work functioning.

Much of the evidence about the treatment and consequences of mental illness also refers to SMD. We know a lot about the problems and possible solutions for people with schizophrenia, for example, but this has limited relevance because very few people have such disorder. Much more evidence is needed about the large group of people with CMD, both in terms of their labour market outcomes and policies to improve those.

6.2. Evidence on the interface between mental health and work

Most people with mental disorders are in work

Employment rates of people with mental disorders are much higher than is generally thought. The employment rate of people with CMD is around 60-70%, or 10-15 percentage points lower than for people with no mental disorder. This seems a high rate but, given the large size of this group, this gap reflects a very large loss to the economy, and for the individuals concerned and their families. The corresponding employment rate of people with SMD is around 45-55%. This is also higher than is commonly known, which is partly explained by the fact that people with the most severe mental illnesses would usually not be included in the reference population used in health surveys.

Many other people with mental disorders want to work but cannot find jobs. Unemployment is a key issue as people with SMD are typically 6-7 times more likely to be unemployed than people with no such disorder, and those with CMD 2-3 times. Moreover, there is a high share of long-term unemployment (as a percentage of total unemployment) for people with SMD, leading to a high risk of discouragement and labour market withdrawal. People with CMD, on the other hand, do not face higher long-term unemployment shares than the general population. This, in turn, indicates that they seem to be able to find jobs as much as any other unemployed person but also that they will

often lose their job again quickly: it is more difficult for people with CMD than for the general population to hold on to their job.

It should also be stressed that unemployment itself is very detrimental to mental health. Unemployment seems to be particularly harmful for mental health initially (caused by an unemployment shock), then there seems to be some adjustment to the situation, before it worsens again in the longer-term. Along the same lines, there is also evidence that people with mental disorders who find a job see significant improvements in mental health. This is in line with clinical findings according to which employment can be an important element in recovery, improving also non-vocational outcomes. This clinical evidence is, however, not reflected sufficiently in mental health policy, which still has a very limited focus on employment.

Work is good for mental health but not under all work conditions

There is increasing evidence suggesting that access to employment is associated with better mental health. However, poor-quality jobs can be detrimental for mental health. This is of concern because workers with mental disorders are more likely than workers without mental illness to work in jobs which do not match well with their skills. They are also more likely to work in low-skilled occupations (clerical work, sales and service work, elementary occupations) more often than others.

This is problematic because these occupations tend to combine, more often than jobs in other occupations, high psychological demand with low decision latitude – a combination likely to lead to *job strain*, *i.e.* unhealthy work-related stress, which indeed is a driver of poor mental health. Moreover, there has been a tendency – as shown by data from the European Working Conditions Survey – for job strain to increase over time in many occupations. This suggests that some of the working conditions relevant for a worker's mental health have indeed worsened.

That said, there are also key workplace variables that can contribute to prevent a worsening of mental health, the most important one being good management, *i.e.* a line manager who supports the worker, gives adequate feedback and recognises the work effort. However, European survey data suggest that far fewer workers with mental disorder have such a manager: less than 60% of those with SMD, compared with 70% of those with CMD and 85% of those with no mental disorder.

Productivity losses through mental ill-health are large

Given that the large majority of people with mental disorder are in employment, a key policy objective should be to ensure that these workers retain their jobs and can work productively. Evidence on productivity losses suggests there is a long way to go in order to achieve this.

Workers with mental disorder are absent from work for health reasons more often than other workers, and if they are, they are away for longer. The incidence of absence in a four-week period is 42%, 28% and 19% for workers with SMD, CMD and no mental disorder, respectively. The corresponding average duration of absence is 7.3, 5.6 and 4.8 days, respectively.

However, many workers with mental disorders do not take sick leave but instead may be underperforming in their jobs. Productivity losses while at work are potentially large, with 88% of all workers with SMD reporting reduced productivity at work in the past four

weeks. The corresponding figure for workers without a mental disorder is only 26%. Importantly, on this measure people with CMD are far more similar to those with SMD, with an incidence of 69%. This finding of substantial productivity losses on the job by people with CMD is one of the most important of the report, highly relevant for the design of an adequate policy response.

Such high losses in productivity suggest that policies directed at sickness monitoring and sickness management are essential. But this approach is not enough because it implies that intervention and support is in many cases coming too late. This, in turn, comes back to the crucial role of good-quality jobs, good working conditions and, in particular, good management. The reality is often very different, with little understanding by management and co-workers (and often also individuals concerned themselves) of mental health and the needs of workers with a mental disorder, leading to much higher rates of dismissal. According to a US study, workers with a mental disorder have a 50% higher likelihood of *involuntary* job loss, and also a 30% increased likelihood of *voluntary* job quits.

Employment is the best way to secure good incomes

Work is also important to ensure adequate incomes. Evidence suggests that people with mental disorder who have a job typically have *average* (per person equivalised household) incomes. But not everyone is employed; accordingly, people with CMD have an income around 90% of those with no mental disorder, and the figure is only 60-80% for those with SMD – with correspondingly higher risks of living in poverty. The main reasons for this difference are the lower employment rate, the higher dependence on benefits, and a higher share of people neither employed nor receiving a benefit.

People with mental disorders often receive unemployment benefits

Inactive people of working-age with a mental disorder are often receiving a disability benefit but many receive *other* working-age benefits. Among people with SMD, roughly half receive a disability benefit and the other half other benefits. Due to their closer connection to the labour market, people with CMD receive other benefits more often than disability benefits, the ratio being roughly 2 to 1. Differences between countries in these "distributions" across benefits are surprisingly small. Only in Norway are there relatively more people with CMD who receive a disability benefit.

Consequently, unemployment benefit schemes in particular, but also social assistance and possibly lone-parent benefits, are as important in designing better policies for people with a mental disorder as disability benefits. The biggest challenge for these systems is the identification of both the problem and the needs arising. There is a considerable lack of awareness of the importance of this issue; for example, public employment services generally have no particular tools for identifying mental ill-health although many of their clients, especially among the long-term unemployed, are suffering from mental health problems. With a few exceptions, in the countries included in this study there are no particular identification tools available and no corresponding statistics either.

The lack of action for the unemployed creates big challenges for the disability benefit system

Evidence from data on new entrants to the disability benefit rolls shows that those with mental disorders typically have been at a greater distance from the labour market at the time of their claim than entrants with other health problems: fewer of them have been

employed in the year(s) prior to their claim and more of them long-term unemployed. This is a major challenge for the disability benefit system. The lack of identification and action in "previous" benefit systems might explain why employment measures offered to disability benefit claimants with a mental disorder tend to be less successful than for other claimants, *e.g.* in the United Kingdom. In turn, the better outcomes for claimants with a mental disorder of employment and rehabilitation measures in Australia compared with the United Kingdom might be related to the better one-stop-shop system of identification and referral. (Data on this issue are largely unavailable for other countries.)

Also for the disability benefit system the challenge is to, first, identify mental disorder and, second, take the right steps in terms of work-capacity assessment, needs assessments and supports. This is urgent in view of the increase in (almost) all OECD countries of the share of disability benefit claims caused by a mental disorder – especially among younger claimants. The reasons behind this increase are not fully understood but, again, the trend is not the result of a higher prevalence of such disorders; and only partly is it due to the bigger labour market challenges these people are facing today.

Many of these claimants have multiple or co-morbid conditions and there appears to have been a shift over time towards taking the mental disorder as the primary health condition as it is the main factor in the person's reduced work capacity. In other words, it seems that the higher awareness and the capacity-limiting view of mental illness have resulted in a shift in identification – without necessarily facing a different clientele. This opens opportunities to do better in helping those people back into work and preventing a long-term disability benefit grant.

However, to date these opportunities have not been fully harvested. Claimants with a mental disorder are too easily classified as being unable to work. They are more often granted a *full* benefit immediately; when they are granted a *temporary* benefit initially this is not *reassessed* properly but turned into a permanent payment later; their claims are less often *rejected*; and they are less likely to *exit* disability benefit for reasons of recovery or employment. This suggests that not enough is being done for this group of claimants to either keep them in work or help them back into employment. The OECD's recommendations on disability benefit system reform (see OECD, 2010) are, therefore, very relevant for those claiming with a mental disorder: Policies need to pay greater attention to keeping people in the labour force and preventing them from moving onto a lifetime benefit.

Comprehensive reform of the disability benefit system has in many cases led to large drops in the number of new benefit claims. Importantly, such reforms – as in the Netherlands, Sweden or Switzerland – have also achieved a rapid decline in the number of new disability claims with mental disorder. In order to be able to assess the success of these reforms, however, more needs to be known about the "fate" of those people (with mental disorder) no longer accessing disability benefit.

Better identification and better policy are hindered by non-disclosure

The challenges for all benefit systems are strongly linked with the issue of disclosure of the underlying reasons for a benefit claim. First, people are often unaware of their mental illness, a situation which is widespread for personality disorders. Second, even if they are aware, they will often choose not to disclose their problems, largely because of the stigma and discrimination attached to mental illness and often negative experiences from the past. In this case, one aim of policy should be to influence systems and workplace

policies to an extent that the advantages of disclosing mental disorders (*i.e.* opening up the possibility for adequate support) outweigh the disadvantages (*i.e.* discrimination and risk of dismissal): to provide people with assistance to manage their personal information in a way so as to access sufficient supports while avoiding unfair discrimination too easily triggered by diagnostic labels.

At the time of a disability benefit claim, people are likely to be willing to disclose their mental illness, provided they are aware of it. But this is a very late stage in the process and a time when, for example, return-to-work programmes are unlikely to succeed. The evidence shows that such programmes are likely to be more effective at a much earlier stage, ideally at the very first longer-term sick leave for reasons of mental ill-health and at a time when work motivation is high.

Under-treatment is a key challenge for the mental health system

Awareness and disclosure of mental health problems is also a big challenge for the mental health system. People unaware of an illness and/or unwilling to disclose their illnesses are unlikely to seek professional advice and treatment. The result is that among those with a CMD, some 80% do not receive any treatment; this is a very high share even though some of those people might not need treatment. Even among those with a SMD, as many as one in two do not seek or receive treatment. Treatment rates are particularly low for young adults. Treatment coverage has increased somewhat in the past two decades for all population groups, in line with an increase in the number of psychiatrists, but there is still a huge gap to be closed.

The low treatment rate is of concern because with treatment most mental disorders can get better. Certainly treatment improves the non-vocational/clinical outcomes, *e.g.* in the form of better mood or higher self-esteem. But there is also evidence that "adequate" treatment also improves work outcomes – with US studies showing a post-treatment employment rate of around 70% for adequate treatment compared to only around 50% for traditional treatment.

However, the identification of adequate treatment is often challenging. Depending on the disorder, it is often a combination of medication and therapy, following minimum treatment guidelines regarding the number and frequency of therapy sessions, the type and duration of medication and the extent of follow-up by the physician to monitor the effects. This is another challenge for the mental health system: not only are treatment rates low, but among those who are treated only about 50% receive adequate treatment, according to clinical studies.

Providing adequate treatment requires a clearer role for general practitioners

The relative lack of adequate treatment again is related to the issues of awareness and disclosure. If seeking support, people predominantly seek support from a general practitioner (GP). GPs are generally not sufficiently trained and qualified to deal with the complexities of mental illness, which is in contrast to the high prevalence of mental disorders in patients in a general practice. They will also have to be trained that sickness absence, *i.e.* prescribing to "rest", is often not a useful answer to a mental disorder and potentially harmful to the patient.

One indication of the problems with treatment is the very high share of those treated with a CMD who receive medication only, rather than a therapy or both. This contradicts

clinical evidence that medication is least effective for CMD and most effective for SMD. In view of the fact that (in many cases only) GPs get to see the overwhelming number of patients with mental disorders, especially those with CMD, much remains to be done to enable them to identify and treat patients properly, including referrals to specialist treatment as necessary. An improved referral routine presupposes a specialist mental health care system that cares about the needs of GPs and is able to provide rapid supports.

The mental health system itself needs to change

The mental health care system also faces two other important system-related challenges. First, the system is directed predominantly towards people with SMD. It is often not well equipped for dealing adequately and comprehensively with the needs of people with CMD, or does not reach those people sufficiently. This is not an efficient use of resources. The strengths of approaches currently directed to people with SMD, such as for example the key elements of supported employment, have considerable potential to help people with CMD back into employment effectively.

Related to this, employers and companies so far are not a real partner for the mental health care system. A systematic approach towards employers does not exist. In line with this and despite the knowledge that employment is an important element in recovery, the mental health care system takes little responsibility for the employment outcomes of their patients. Accordingly, to date, mental health care quality indicators do not include any element of employment.

6.3. New directions for mental health and work policies

Policy can and must respond more effectively to the challenges for labour market inclusion of people with mental illness. A three-fold policy shift will be required thereby giving more attention to: *i)* common mental disorders and also sub-threshold conditions; *ii)* disorders concerning the employed as well as the unemployed; and *iii)* preventing instead of reacting to problems.

Two elements stand out as particularly important for policy makers: first, to intervene at the right time; and second, to co-ordinate interventions in a much better way. The early onset of most mental disorders implies a need for a different way of looking at prevention and early intervention. Intervening when people claim a disability benefit will be far too late in most cases. The system complexity implies that progress can only be made by thinking beyond silos and integrating specialists and vocational supports into the first-line treatment.

Early intervention at various points in time

Intervention during adolescence

The early onset of most mental disorders implies a need for a different way of looking at prevention and early intervention. Intervening when people claim a disability or maybe any other public benefit will be far too late in many cases. Help should be provided much earlier by:

- preventing mental disorders at an age when adolescents attend school or undergo an apprenticeship, with early intervention and referral to services as appropriate;
- intervening early and assertively for pupils who display behavioural problems and, thereby, preventing school drop-out;

- assuring better education outcomes for early school leavers who are particularly at risk of developing mental health problems, through apprenticeships and second-chance school programmes; and
- helping youth with mental disorders in their transition from adolescence to adulthood and from mandatory to higher education and into employment.

Intervention at the workplace

The high rate of employment among people with mental disorders and the high productivity losses of those workers mean that the workplace is a key target for mental health policy aimed at improving and sustaining labour market inclusion of those with mental illness. Again, policy intervention is needed in different but concerted ways by:

- securing good working conditions which avoid job strain on the one hand, and sound management practices on the other, to avoid the development of work-related mental health problems and to minimise productivity losses of workers caused by such problems;
- systematic monitoring of sick-leave behaviour to detect longer-term or repeated absences as early as possible and manage those by providing immediate retention support; and
- helping employers avoid unnecessary dismissal caused by mental health problems through the provision of adequate incentives, information and support.

Intervention for the unemployed

Today, too many workers with mental illness lose their jobs and become unemployed, and struggle in finding a new job. As a consequence, they face a high risk of long-term unemployment and permanent labour market withdrawal. Added to this, a large number of the long-term unemployed develop mental health problems; a vicious circle. Caseworkers in the employment service have yet to deal with this issue adequately. Improvements should be sought in a number of ways by:

- making efforts to identify systematically unemployed and especially long-term unemployed suffering from mental ill-health, and assessing their work capacity and their support needs;
- working together with employers to help the unemployed with mental illness find jobs;
- directing return-to-work services to people on longer-term sick leave (or to recipients of longer-term sickness benefit) due to a mental health problem; and
- replacing ineffective vocational support services with effective, evidence-based (or at least experience-based) services and reinforcing outcome measurement.

Intervention for disability benefit claimants

Many of those with mental ill-health applying for a disability benefit are excluded from the labour market and trapped on long-term inactivity benefits too quickly and permanently. Preventing new disability benefit claims to the extent possible and helping beneficiaries who are able to work in their return to employment will require:

- better assessment of the problems of claimants with mental disorders, who typically suffer from complex, co-existing and chronic illnesses, and better identification of their work capacity and support needs;

- strengthening of the requirements for both benefit applicants (in line with their capacities) and benefit authorities, *i.e.* strengthening the activation elements of the disability system; and
- enabling those on disability benefits already to leave benefits through making work pay and introducing steps to eliminate the fear of benefit loss, together with better-targeted return-to-work measures adequate for those with significant distance to the labour market.

Co-ordinated supports at all stages

The main policy challenges and the nature of the interventions and supports needed at different stages of the (working) lifecycle are structurally similar at all stages. They involve better integrated services with the participation of a range of actors and systems to work together, to share client information and to refer clients to each other. Adequate, timely and well co-ordinated supports will require co-operation and co-ordination – at different times and in different ways – of employment services, health services, education institutions and benefit authorities.

Integration of approaches and services that often operate in isolation will require aligning objectives and incentives of the different systems that serve individuals with mental disorders. In the longer run, all stakeholders would benefit from the provision of integrated and effective supports and minimising system failures that hinder the provision of appropriate services. For example, integrating mental health services within the education system has positive impacts on educational attainment and other outcomes for children with mental health problems. Similarly, the integration of clinical and vocational services is associated with improved employment outcomes.

Health services in particular tend to be isolated and disconnected from other systems, with little or no emphasis on employment despite strong evidence that work is good for mental health and an important tool in a broader treatment strategy. This has also to do with the strong focus of current mental health systems on people with a severe mental disorder. Refocusing to address more effectively challenges of people with common mental disorders can only be done through a better co-ordination with other systems and a strong co-operation with both employers and employment services. Treatment services alone do not sufficiently help with continuing education and retaining employment.

The solution probably lies in *how* programmes are being co-ordinated. Promising approaches are to enable the mental health service to directly employ an employment specialist to help clients get and keep a job, and to form a formal partnership between health and employment services to provide a new joint service that encompasses employment and higher education as part of the recovery plan.

The high prevalence of mental disorders among children, workers and the unemployed also means that several stakeholders outside of the specialised mental health treatment sphere have a very critical role to play. Teachers, managers, public employment service caseworkers and general practitioners are key actors in tackling mental health and work challenges in a new way. They need to be more aware of mental disorders and better qualified to play the role they will have to play for employment outcomes to improve. None of them need to be psychiatrists, but they will have to be empowered to be able to support their pupils/workers/jobseekers/patients, to provide enhanced care and to co-operate with and involve experts systematically whenever needed.

Efforts are needed to improve the evidence base which continues to be incomplete

Last but not least, all countries – or, all key institutions in all countries – will have to make further efforts to improve the evidence base. The unawareness of, and stigma attached to, mental illness have led to a blind spot in all of the systems involved in terms of their data collection systems.

Most importantly, more evidence is needed on the link between health and employment outcomes. For example, the mental health care system should systematically collect information about the employment status of patients before and after treatment. Similarly, the public employment service should collect information about the mental health status and needs of their clients.

Finally, more research is required to identify good country examples of where a more integrated approach to the treatment and prevention of mental disorders is being adopted. This is the objective of the next phase of the OECD's review on the issue of mental illness and work.