Eurofound

Active inclusion of young people with disabilities or health problems

Background paper

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Wyattville Road, Loughlinstown, Dublin 18, Ireland. - Tel: (+353 1) 204 31 00 - Fax: 282 42 09 / 282 64 56
email: postmaster@eurofound.europa.eu - website: www.eurofound.europa.eu

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Introduction

The causes of the rising rates of exclusion and dependency in the population of young people with health problems are acknowledged to be complex and multi-dimensional. They include the same challenges as those facing the majority of young people leaving compulsory education and seeking access to the labour market, as well as additional barriers created by: societal attitudes, the attitudes and expectations of their families, direct and indirect discrimination, difficulties in obtaining reasonable accommodation, lower qualifications and skills, overcoming the effects of institutionalisation, and the lack of appropriate and coordinated systems and services to support labour market participation. In the case of each individual, health and personal factors will also have a bearing.

One of the challenges in exploring trends in the labour market integration or social exclusion of young people across the EU is the lack of consistency in the way in which young people are characterised in terms of age and in the data that are gathered and reported. For the purposes of this report, young people are considered to range from 16 to 34 years. Within this age range, there are two distinct groups facing different barriers to labour market inclusion. The younger age group (16–24 years) can be considered as attempting to make the transition from education to employment, with all the complexities that this entails. Within the older age group (25–34 years), some people have obtained a job and are facing exclusion from the workplace as a result of health factors, others are attempting to return to work after losing a job and still others may be faced with moving from sheltered to open employment.

This report reviews the evidence to support the contention that increasing numbers of young people from both age groups are entering the disability benefits system. It attempts to place this evidence within the context of the many factors that are known to influence the economic activity and labour market participation of young people with disabilities. The study also aims to document any measures targeted at young people with health problems to promote labour market inclusion and the ways in which these systems operate and interact. It makes specific reference to active inclusion measures, including the role of social, health and employment services, as well as educational systems and social partners. In addition, the report refers to the ways in which long-term illness or disability among young people is responded to at a local level, particularly in the context of deteriorating economic and labour market conditions.

In order to characterise and describe the complex factors involved in social exclusion and the drift to economic inactivity by young people with health problems, a Policy Analysis Tool has been adapted for use in the current context. This tool was originally developed to analyse the structural and system factors operating in the progressive exclusion of long-term absent employees from the workplace.[1] Using this framework, factors and measures with relevance to the threshold between compulsory education and active working life or economic inactivity have been analysed in terms of their purpose, intended outcome, target beneficiaries and responsible actors. Within this framework, the study has paid particular attention to the role of employment guidance services[2] in offering young people with health problems access to employment and how these services are responding to emerging needs and trends.

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[1] Wynne, R. and McAnaney, D., European Foundation for the Improvement of Living and Working Conditions (Eurofound), *Employment and disability: Back to work strategies*, Luxembourg, Office for Official Publications of the European Communities, 2004, available online at: **http://www.eurofound.europa.eu/publications/htmlfiles/ef04115.htm**.

[2] Wynne, R., McAnaney, D., O'Kelly, C. and Fleming, P., Eurofound, *Employment guidance services for people with disabilities*, Luxembourg, Office for Official Publications of the European Communities, 2006, available online at: **http://www.eurofound.europa.eu/publications/htmlfiles/ef0633.htm**.

The threshold approach to describing the active inclusion process goes beyond the medicalisation of ill-health and disability which has been implicated in the documented rise in incapacity benefit claimants.[3] It incorporates personal factors, structural and process systems factors, employer-related factors and economic factors. This approach is compatible with the International Classification of Functioning, Disability and Health (ICF)[4] of the World Health Organization (WHO), which is the most comprehensive and widely accepted framework for understanding the nature of impairment, activity and participation. The ICF is a detailed system for categorising a person's functioning, activity limitations and participation restriction, and the environmental and personal factors that influence these. It provides a way of analysing and describing exclusionary factors and inclusionary measures, not only for the subgroup of young people with disabilities but for all young people attempting to make the transition to active labour market participation and community involvement.

These frameworks have been used to provide a systematic approach to clarifying the multiple and complex factors which influence the activity and participation of young people experiencing reduced functioning or productivity due to a health condition. The report puts a particular focus on macro-environmental factors such as laws and regulations and mediating mechanisms such as supports and incentives, as well as fiscal constraints and administrative procedures aimed at the young people's active inclusion in vocational training, the labour market and the community.

Youth, disability and social protection

Age has a significant influence on a person's employability. It is well accepted that older workers are at greater risk of labour market exclusion and economic inactivity than their younger colleagues. However, young people are also disadvantaged in the labour market. Young persons aged 16–24 years with health problems or disabilities making the transition from school to work face the double challenge of being young in a labour market where knowledge, skills, experience and qualifications are at a premium and of being at risk of explicit and implicit discrimination on the grounds of their disability. Young people aged 25–34 years who are established in the labour market are also at risk of exclusion if they develop a health problem that impacts on their work capacity.

According to the International Labour Organization (ILO), over half of the world's unemployed people are aged under 25 years.[5] Young people in general between the ages of 18 and 25 years in some Member States are experiencing significantly higher levels of unemployment and underemployment in comparison to older workers, despite being better educated and representing a smaller total proportion of the population than previous generations. As reported by the Youth Event Slovenia 2008[6], 4.7 million young people are unemployed in Europe. According to a report on the emergency plan for employment in France, the year on year increase in youth unemployment at the end of March 2009 was 35.8% and structural unemployment for young people is likely to remain high.[7] While there are many possible explanations for this, it may well be that the rising level of young people with disabilities moving into the social protection system is not in fact specific to this group but is in part due to a wider issue relating to the dynamics of the labour market in general. Nevertheless, the rate of increase in unemployment may be higher for young people with disabilities.

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[3] OECD, High-Level Policy Forum on 'Sickness, disability and work: Addressing policy challenges in OECD countries', 14 May 2009, Comments of the Rapporteur Michael Wiseman, available online at: **http://www.oecd.org/dataoecd/4/20/42857616.pdf**.

[4] **http://www.who.int/classifications/icf/en/**.

[5] ILO, *Improving prospects for young women and men in the world of work – A guide to youth employment*, Policy considerations and recommendations for the development of national action plans on youth employment, Geneva, ILO, 2004.

[6] **http://www.youth-event-slovenia.si/**.

[7] 'A plan to fight youth unemployment in France', *The Economist*, 14 May 2009.

Negotiating transitions between life stages can present complex and intimidating challenges regardless of the age, intelligence, experience or expectations of the individual in the midst of the transition process. During transitions from primary to secondary school, from education to the world of work or from employment to retirement, many perplexing and unforseen factors can intervene. One of the most demanding transitions in the career path of young people is the progression from compulsory education to vocational training, work or further/higher education. If successful, it can lay the foundation for a constructive and productive adult life. However, if difficulties are encountered, it can impact on the individual's self-esteem and confidence, career prospects, and future economic and social status, as well as having implications for the person's emotional and mental health. For some young people with health problems or disabilities, additional factors can come into play. In such cases, the role of the environment – including the young person's family – in providing appropriate and timely support and intervention is particularly crucial.

For those in the 25–34 age group, the challenges are different. The key issues at this phase in a person's career path are keeping or changing jobs and progressing within a chosen occupation or career. The impact of an emerging or acquired health problem or disability at this point in a person's career can be devastating, particularly if it impacts on workability and productivity, and can lead to a life of dependence on disability income supports and social exclusion services.

In the first quarter of 2009, the seasonally adjusted unemployment rate in the EU27 for people aged 15–24 years was 18.3%, significantly higher than the total unemployment rate of 8.2%. Moreover, youth unemployment rates are rising faster than the total unemployment rate. Between the first quarter of 2008 and the first quarter of 2009, the youth unemployment rate in the EU27 rose by 3.7 percentage points, while the total unemployment rate increased by 1.5 percentage points.

From a disability perspective, the economic inactivity rate for young people with disabilities between 16 and 24 years of age was 49.2%, compared with 16.7% for people with disabilities in the 25–34 age group. Clearly, some of this difference is due to attendance at full-time education. While a direct comparison between disabled and non-disabled young jobseekers is not available, the disability employment rate regardless of age is not favourable. Only 40% of disabled people are employed, while this rate is 64.2% for persons without a disability.[8]

Evidence that economic inactivity rates among young people with health problems or disability are not simply explained by attendance at education can be gleaned from other sources. Table 1 (next page) presents an overview of indicators on the take-up of benefits by young people.[9] It also illustrates the difficulties facing any endeavour to provide a tidy synthesis of the information available. This information originates from different years, relates to different age groups – where this is actually specified – and derives from different sources. Member States apply different definitions, eligibility criteria and legislation, and adopt distinct approaches to the design and structure of the social protection system. In addition, procedures for data gathering and statistical mechanisms can influence the figures from each country and make comparisons more difficult.

[8] European Commission, European Social Fund (ESF) coordination, *Addressing the needs of people with disabilities in ESF programmes in the 2007–13 period*, Brussels, available online at: **http://ec.europa.eu/employment_social/esf/docs/peopledisabilities_en.pdf**.

[9] Derived from a Eurofound background document of March 2009.

Table 1: *Young people in receipt of disability benefits or economically inactive*

	Year	Type of indicator	Comparator	Age group	Unit	% / % change	Source
BG	2005	Taking up benefits	Benefit claimants	< 18	%	34.7	Bulgarian Ministry of Labour and Social Policy
BG	2006	Taking up benefits	Benefit claimants	< 18	%	8.9	Bulgarian Ministry of Labour and Social Policy
BG	2007	Taking up benefits	Benefit claimants	< 18	%	3	Bulgarian Ministry of Labour and Social Policy
CH	1995–2007	Taking up benefits	Benefit claimants	20–34	% change	21	OECD, Sickness, disability and work, 2007
CH	2002–2007	Taking up benefits	Benefit claimants	All	% change	15.5	Federal Social Insurance Office
ES	1995–2005	Taking up benefits	Benefit claimants	20–34	% change	30.8	OECD, Sickness, disability and work, 2007
FI	1996–2007	Taking up benefits	Benefit claimants	16–19	% change	10.5*	Social Insurance Institution of Finland
FI	1996–2007	Taking up benefits	Benefit claimants	20–24	% change	27*	Social Insurance Institution of Finland
FI	1996–2008	Taking up benefits	Benefit claimants	25–29	% change	6.6*	Social Insurance Institution of Finland
LU	1995–2008	Taking up benefits	Benefit claimants	20–34	% change	-57.8	OECD, Sickness, disability and work, 2007
NO	1990–2005	Taking up benefits	Benefit claimants	20–34	%	29.6	OECD, Sickness, disability and work, 2007
NO	1995–2005	Taking up benefits	Benefit claimants	20–34	% change	29.6	OECD, Sickness, disability and work, 2007
PL	1995–2005	Taking up benefits	Benefit claimants	20–34	% change	-22.1	OECD, Sickness, disability and work, 2007
SK	2004–2007	Taking up benefits	Benefit claimants	< 17	% change	40	Slovakian Ministry of Labour, Social Affairs and Family
UK	1995–2009	Taking up benefits	Benefit claimants	20–34	% change	21.2	OECD, Sickness, disability and work, 2007
UK	1999–2007	Not in education, employment or training (NEET)	Not specified	16–25	% change	32	New Deal for Disabled People

Notes: *CH = Switzerland. NO = Norway. See annex for list of EU Member State country codes. *Calculated from figures in Eurofound background report, 2009.*

The statistics in Table 1 have been extracted from various sources, including a query made by Eurofound to its network of national contacts. These data provide support to the case that there has been a substantial increase in the number of younger people with health problems accessing the disability benefits system across the EU. The age groups for which data are reported vary from under 17 years to 20–34 years. The time periods for which data are reported also vary. The most consistent data are available from the OECD reports on *Sickness, disability and work: Breaking the barrier*s (2006 and 2007).

Despite these data inconsistencies, evidence emerges of an increasing trend in the take-up of disability benefits by young people with health problems or disabilities. This is seen in the majority of countries for which data are available, apart from Luxembourg and Poland. This increase in the inflow rates to disability schemes takes place in a context in which most countries have introduced measures to reduce unemployment and economic inactivity rates of persons with disabilities. Furthermore, the EU Integrated guidelines for growth and jobs[10] have specifically targeted both young people and people with disabilities.

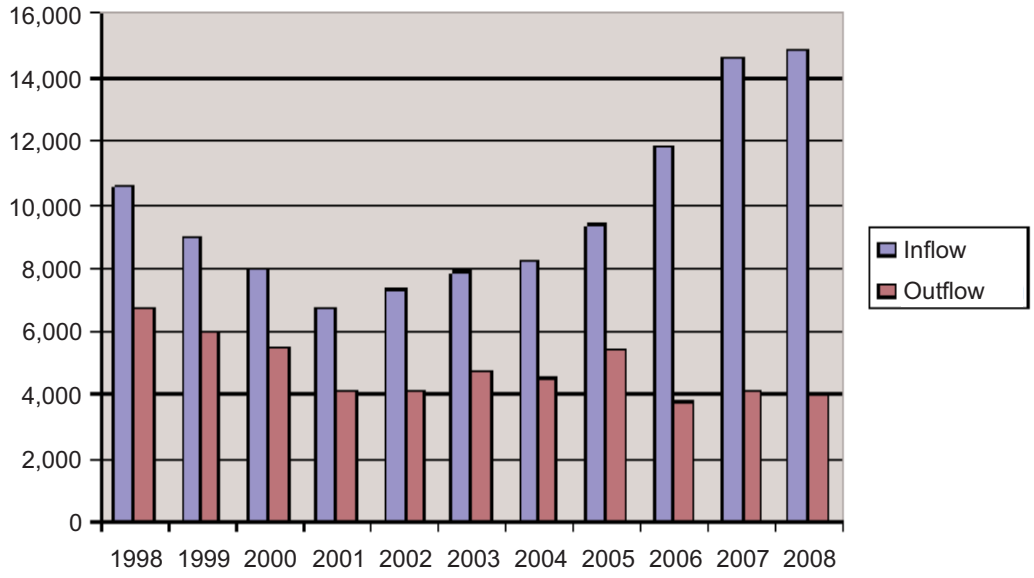
On the basis of this evidence, Member States may well be facing a social exclusion challenge in which the interaction between age and disability is important for both older and younger people. One of the countries which has clearly documented a significant increase in the number of younger people taking up disability benefits is the Netherlands. The numbers have risen sharply and currently one in 20 persons aged 18 years is enrolled in a scheme based on the Disablement Assistance Act for Disabled Young People (*Wet arbeidsongeschiktheidsvoorziening jonggehandicapten, Wajong*). Once awarded, this benefit for people who are disabled at 17 years can be continued until the age of retirement. The inflow into this disability scheme has now tripled compared with 10 years ago – by 2006, the inflow into the scheme represented 6.8% of all people aged 18 years. If the present trend continues, this group will eventually constitute 5% of the workforce.

A study conducted by the Work and Employment Division of the Netherlands Organisation for Applied Scientific Research (*Nederlandse Organisatie voor toegepast-natuurwetenschappelijk onderzoek*, TNO Arbeid) showed that one in 15 young people claims and receives a Wajong disability benefit before the age of 30 years. Another study estimated that, under present policies, the number of Wajong benefit recipients will increase from 156,000 persons in 2006 to 300,000 and possibly 360,000 people in 2040. Of the current 156,000 recipients, 9% have a regular job and 17% have a job in sheltered employment. This 26% participation rate is deemed very low since at least half of the Wajong recipients are considered to be able to work in some way.[11] Figure 1 (next page) illustrates the trends in terms of recipients' inflow and outflow from the system.

[10] Employment policy guidelines (2005–2008), **http://europa.eu/legislation_summaries/employment_and_social_policy/growth_and_jobs/c11323_en.htm**.

[11] Schoonheim, J. and Smits, J., *Report on the employment of disabled people in European countries*, Academic Network of European Disability experts (ANED), VT/2007/005, 2007.

Figure 1: *Inflow and outflow of Wajong recipients, 1998–2008*



Source: *Data from Edwin de Vos, TNO Arbeid*

An examination of claimants of Disability Benefit (a contributory benefit) and Disability Allowance (a non-contributory benefit) in Ireland reflects a similar increase in younger people entering the benefits net (see Table 2 on p.7). This trend has been accelerating since 2006 particularly for Disability Allowance and for young people aged under 25 years.

Similar experiences are noted in the Nordic countries. In Norway, the inflow rate in the disability or incapacity scheme has increased mostly among young people aged 20–34 years, with little increase among those aged over 50 years.[12] In Denmark, despite numerous reforms, the proportion of young claimants taking up disability benefits is growing. In the United Kingdom (UK), all of the recent increase in the receipt of disability benefits is due to younger persons and prime-age persons, whereas the beneficiary rate among people aged 50–64 years has hardly changed. In Spain, the beneficiary rate of the youngest age group increased by almost one third, while that of older people aged 50–64 years declined by 10%.

In the UK, the structure of the disability benefit population has changed substantially during the past decade. Compared with 10 to 15 years ago, the recipient today is more likely to be a young person, a woman and a recipient of a non-contributory benefit due to a limited work history. Interesting data are emerging from the New Deal for Young People. The number of young persons aged 16–25 years who are not in education, employment or training (so-called NEETs) has increased by 32% between 1999 and 2007. In the New Deal for Disabled People activation measure, according to data from the Department of Work and Pensions (DWP), only 6.2% of Incapacity Benefits claimants take part in the scheme, prompting questions as to whether it has a significant role in improving their employment chances.

[12] OECD, *Sickness, disability and work: Breaking the barriers*, Vol. 1: Norway, Poland and Switzerland, Paris, OECD, 2006.

Table 2: *Disability Benefit and Disability Allowance recipients, by age (Ireland)*

Disability Benefit							
Age group	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**% increase**
Under 25 years	1,945	2,063	2,075	2,015	2,071	2,189	12.54
25–29 years	3,236	3,691	3,770	3,939	4,211	4,423	36.68
30–34 years	6,064	6,503	6,683	6,777	6,962	6,892	13.65
35–39 years	7,441	7,706	8,044	8,506	9,008	9,045	21.56
Disability Allowance							
Age group	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**% increase**
Under 25 years	10,083	10,269	10,415	10,575	12,381	13,139	30.31
25–29 years	6,604	7,054	7,427	7,795	6,527	7,045	6.68
30–34 years	6,683	7,229	7,819	16,379 (30–39 years)	8,274	8,715	30.41
35–39 years	6,938	7,365	7,908		8,943	9,535	37.43

A similar trend is found in other EU countries. The *Employment in Europe 2007* report concluded that, from the age of 19 years, a fairly stable proportion of 17%–19% of young people are not in education, employment or training and thus could potentially represent a challenge for policymakers. [13]

A possible explanation for the increase in young people with health problems or disabilities is that there is a corresponding increase in the incidence of recorded disability among younger age groups. Evidence for such a trend is limited and difficult to interpret for many of the same reasons described above. Table 3 (on p.8) presents the proportion of young people reporting long-standing health problems or disabilities in the EU.[14] The data indicate that disability is less prevalent in the 16–24 age group than among older people.

Data from some Member States also support the view that the number of young people with documented health problems or disability in the population has increased. This is particularly visible in several countries, including Denmark, Finland and Poland. In Poland, for example, 4.2% of the 15–29 age group are registered as being disabled.

In Slovakia, no unified statistics provide an overview of the number of children and young people with disabilities, due to the various definitions of disability that exist and apply in different systems. However, examining the Slovakian social benefits statistics reveals an increase in the number of young people with disabilities. In the UK, from 1990 to 2000, the number of young people with disabilities increased modestly within the population from 18% to 19%.

[13] European Commission, Directorate-General for Employment, Social Affairs and Equal Opportunities, *Employment in Europe 2007*, Luxembourg, Office for Official Publications of the European Communities, 2007, available online at: **http://ec.europa.eu/social/main.jsp?catId=89&langId=en&newsId=542**.

[14] Adapted from Eurostat *Percentual distribution of severities of disability by sex and age group* (date updated: 21 April 2009), accessed on 9 August 2009, **http://nui.epp.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_db_emseag&lang=en**.

Table 3: *Disability levels among young people, EU (%)*

	No disability			Disability		
	Total	16–24 years	25–29 years	Total	16–24 years	25–29 years
EU25	83.8	92.7	91	16.2	7.3	9
EU15	82.2	91.3	89.7	17.8	8.7	10.3
AT	87.2	94.8	93.2	12.8	5.2	6.8
BE	81.6	93.8	89.8	18.4	6.2	10.2
CY	87.8	96.8	95.7	12.2	3.2	4.3
CZ	79.8	91.7	90.3	20.2	8.3	9.7
DE	88.8	96.5	95.4	11.2	3.5	4.6
DK	80.1	88.4	87	19.9	11.6	13
EE	76.3	90.6	88.5	23.7	9.4	11.5
EL	89.7	97.4	96.9	10.3	2.6	3.1
ES	91.3	97.1	95.9	8.7	2.9	4.1
FI	67.8	84.2	80.4	32.2	15.8	19.6
FR	75.4	88.1	83.6	24.6	11.9	16.4
HU	88.6	98.7	97.7	11.4	1.3	2.3
IE	89	95	93.8	11	5	6.2
IT	93.4	97.9	97.2	6.6	2.1	2.8
LT	91.6	97.9	95.2	8.4	2.1	4.8
LU	88.3	96.7	94.1	11.7	3.3	5.9
MT	91.5	97.3	95.6	8.5	2.7	4.4
NL	74.6	86.3	83	25.4	13.7	17
PT	80.1	92	90.1	19.9	8	9.9
RO	94.2	98.7	97.5	5.8	1.3	2.5
SE	80.1	89.6	86.3	19.9	10.4	13.7
SI	80.5	94.2	93.3	19.5	5.8	6.7
SK	91.8	98.3	97.5	8.2	1.7	2.5
UK	72.8	84.2	82.6	27.2	15.8	17.4
NO	83.6	91.2	89.9	16.4	8.8	10.1

Notes: *See annex for country groups and codes. No data for Latvia. Data updated 21 April 2009.*
Source: *Adapted from Eurostat, 2009 (see footnote 14)*

In Hungary, the number of disabled young people has been growing since 1980. In Norway, from 1990 to 2008, the proportion of persons on disability pension aged 18–66 years has increased from 8.4% to 11%. Men are somewhat overrepresented among young people aged 18–29 years on disability pensions.

It is important to see whether these figures represent an increase over recent years. Some evidence that this is the case comes from comparing disability rates in 1996 with current figures (Table 4). While not directly comparable, data from the report *Disability and social participation in Europe* (Eurostat, 2001) can be related to the latest figures.[15] The categorisation of severity of disability, the age groups reported on and the number of Member States differ between the two time frames. Nevertheless, the figures reflect a substantial increase in the incidence of self-reported disability. It is also interesting to note that economic inactivity rates have declined in the 16–24 age group but have increased in the 25–34 age group.

Table 4: *Comparison of disability and activity rates, 1996 and 2009 (%)*

	1996 (14 EU Member States*)			2009 (EU15)			
		Economic inactivity			Economic inactivity		
	Incidence of disability	Severe disability	Moderate disability	Incidence of disability	Very severe disability	Severe disability	Some disability
16–19 years	6.6	81.3	52	8.7	75.8	49	38.8
20–24 years	6.1	43.2	46.9				
25–29 years	7.2	38.8	28.5	10.3	68.1	34.9	34.9
30–34 years	8.3	49.4	28.4				

Note: * *No data for Sweden.*
Source: *Eurostat*

Policy context

EU policies address the employment and social inclusion needs of young people and people with disabilities in significant detail and assign priority to both groups. The policy challenge is to ensure that these two complementary fields of policy operate in a coordinated manner to address the specific needs of young people with health problems. Mainstreaming of both youth and disability issues into all policy fields is one recommended strategy. A further goal is the integration of measures addressing youth and disability into an approach that focuses on the needs of those facing the multiple challenges associated with being young and having a disability.

A recent Communication from the European Commission identified specific challenges for young people in terms of education, employment, social inclusion and health.[16] One fifth of 16–24 year olds were at risk of poverty in 2006. The Commission states that exclusion may be caused by unemployment, disability, societal and individuals' attitudes towards migration, discrimination, physical and/or mental health, addictive behaviour, abuse, family violence or a criminal record. Greater collaboration between youth policies and other policy areas such as education, employment, inclusion and health are required to create a more consistent and coordinated response to these challenges.

[15] Eurostat, *Disability and social participation in Europe*, Luxembourg, Office for Official Publications of the European Communities, 2001, available online at: **http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/publication?p_product_code=KS-AW-01-001**.

[16] European Commission, Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions, *An EU strategy for youth: Investing and empowering – A renewed open method of coordination to address youth challenges and opportunities*, COM(2009) 200 final, Brussels, 27 April 2009, available online at: **http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0200:FIN:EN:HTML**.

Referring to the EU Health Strategy, *Together for health: A strategic approach for the EU 2008–2013* (COM(2007) 630 final)[17], the Council of the European Union identifies health as a priority for action for young people.[18] Many young people are at risk because of stress, poor diet, lack of physical exercise, unprotected sex, tobacco, alcohol and drug abuse. It is recommended that employment policy action in Member States and at EU level should be coordinated across the components of flexicurity – combining labour market flexibility and employment security – alongside flexible contractual arrangements, active labour market measures, lifelong learning and modernised social security systems, in order to facilitate transitions from school to work or from economic inactivity or unemployment to work. In this regard, EU funds – especially the European Social Fund (ESF) – must promote youth employment. Non-formal education for young people should be supported to contribute to lifelong learning by developing its quality, recognising its outcomes and integrating it better with formal education. The mobilisation of all actors involved in the life of young people, including parents, teachers, social workers, health professionals and young people themselves, is considered fundamental to poverty prevention and promoting the social inclusion of young people.

The European Commission Communication on the *Situation of disabled people in the European Union: the European Action Plan 2008–2009* (COM(2007) 738 final)[19] reflects the European commitment to ensure that disabled people are able to enjoy their rights. The Communication highlights the strong correlation between disability and ageing, the disproportionate exclusion of disabled people from the labour market and the particularly disadvantaged position of women with disabilities. It expresses serious concern at the level of labour market exclusion of disabled people, not only from the perspective of equal opportunities but also from an economic imperative to make the most of the untapped potential of disabled persons. People with learning or intellectual disabilities in the labour market are given specific mention.

The Commission proposes a range of mechanisms which can make a difference between a disabled person being active in the labour market and being dependent on social welfare, including creating new jobs – not least to meet the increasing demands of an ageing population. The Communication recommends a comprehensive approach to increase the employment rate of people with disabilities.

Of particular interest is the emphasis on supported employment (SE); this refers to personal assistance and workplace adaptations taking into consideration the needs of disabled people in open employment. SE has been emphasised explicitly as an important measure in increasing the employment rate of people with disabilities and can be considered to be congruent with a number of EU policy areas. It represents one element of flexibility and security in the labour market.[20] SE is a way to assist jobseekers entering the market for the first time to access employment and to help those who are in employment to retain their jobs or to redeploy to another position. It also has a useful role to play within an active labour market policy (ALMP), given its emphasis on assisted job search and activation through better job matching. It is in effect an enhanced job placement strategy but with the added value of job support and follow up.

[17] **http://ec.europa.eu/health/ph_overview/Documents/strategy_wp_en.pdf**.

[18] Resolution of the Council and the Representatives of the Governments of the Member States, meeting within the Council of 20 November 2008 on the health and well-being of young people (2008/C 319/01), available online at: **http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2008:319:0001:0003:EN:PDF**.

[19] **http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2007:0738:FIN:EN:HTML**.

[20] European Commission, Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, *Towards common principles of flexicurity: More and better jobs through flexibility and security*, COM(2007) 359 final, Brussels, 27 June 2007, available online at: **http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2007:0359:FIN:EN:HTML**.

While SE was developed in the field of disability, it is currently being explored as a useful ALMP strategy for all people experiencing difficulties accessing the labour market, including young people, as it is acknowledged that young persons entering the labour market may need extra support. This can include training linked to jobs, access to further studies for future labour market success, apprenticeships in companies and the public sector, more opportunities for learning mobility and action to reduce the number of early school leavers. Early opportunities for training or work should be offered no later than one month after becoming unemployed for 15–19 year olds, and within two months for 20–24 year olds. The EU Lifelong Learning Programme should also be mobilised.[21]

The ESF Regulations 2007–2013 make specific reference to promoting pathways to integration and re-entry into employment for disadvantaged people, such as those with disabilities (Art.3.1.c (i)), and SE has the potential to contribute to this in a substantial way.[22] The development of more effective SE services is also supported by the EU Employment Guidelines in terms of a life-cycle approach to work, active and preventive labour market measures, and flexibility and security.[23] This includes activation through work practice or a job, combined where appropriate with ongoing job search assistance and ensuring that people who become unemployed remain closely connected to the labour market. The SE approach can contribute to attaining these objectives by removing barriers to the labour market particularly for persons at a distance from the labour market, such as young people or those with disabilities.

The EU Disability Action Plan for 2008–2009 highlights the need to encourage SE and to help corresponding programmes to achieve their potential.[24] SE is considered to be part of a comprehensive approach to increase the employment rate of people with disabilities in combination with flexible employment schemes, active inclusion and positive measures complementing non-discrimination legislation.

Greater attention should be paid to the requirements of enterprises in order to match labour market needs. Providers of employment services should coordinate with employers in designing vocational training and rehabilitation services. It is also important to improve the accessibility of employment services and the mainstreaming of disability in Member States' National Reform Programmes, encouraging national targets.

[21] European Commission, Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of Regions, *A shared commitment for employment*, COM(2009) 257 final, Brussels, 3 June 2009, available online at: **http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0257:FIN:EN:HTML**.

[22] European Commission, European Social Fund (ESF) coordination, *Addressing the needs of people with disabilities in ESF programmes in the 2007–13 period*, Brussels, available online at: **http://ec.europa.eu/employment_social/esf/docs/peopledisabilities_en.pdf**.

[23] Council Decision of 15 July 2008 on guidelines for the employment policies of the Member States (2008/618/EC), Brussels, 2008, available online at: **http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2008:198:0047:0054:EN:PDF**.

[24] European Commission, Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions, *Situation of disabled people in the European Union: the European Action Plan 2008–2009*, COM(2007) 738 final, Brussels, 26 November 2007, available online at: **http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2007:0738:FIN:EN:HTML**.

The OECD report on transforming disability into ability (2003) proposed a number of policy changes to improve the labour market opportunities of people with disabilities.[25]

- The report considers it critical that the term 'disabled' should not be equated with 'not being able to work'.
- This strategy should be complemented by a stronger emphasis on activation measures.
- A full range of disability-related services should be available to every person with a disability according to their needs and not based on eligibility for disability benefits.
- The report calls for a change in attitude of all actors involved in disability issues, including employers. To achieve this, it recommends a balance between negative incentives, such as quotas and sanctions, and positive incentives – for example, job subsidies.
- Older people with disabilities aged over 45 years should be targeted by training and rehabilitation programmes.
- Agencies responsible for employment and social protection need to acknowledge that disability is difficult to assess and that the term 'disability' covers a heterogeneous population requiring more flexible approaches to eligibility for services and benefits – for example, partial benefits and more flexible access to rehabilitation and disability-specific employment services.

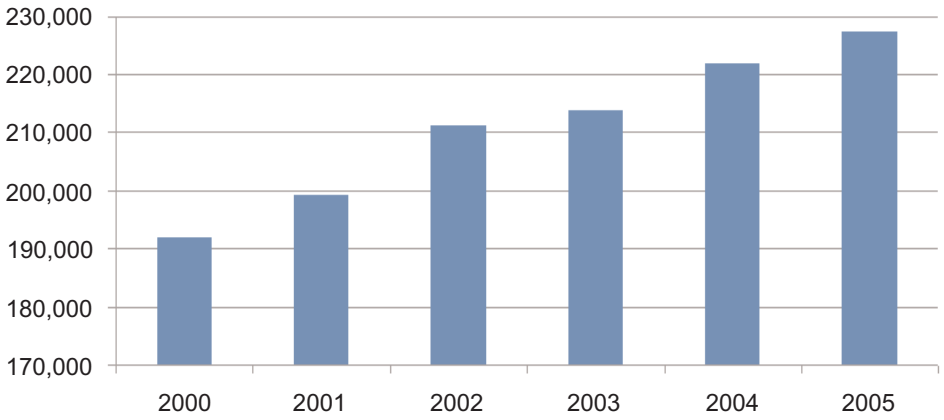
The report concluded that the economic cost of disability to society was substantial and increasing at a high rate. This was at a time when job demand was growing in many countries.

The employment and social protection environment has changed since the publication of this report. Currently, average expenditure by OECD countries is about 1.2% of gross domestic product (GDP) on disability benefits alone. This is over 200% more than unemployment benefit expenditure and has been increasing over the past 15 years. Within the 25 EU Member States before the accession of Bulgaria and Romania in 2007 (EU25), this proportion is much greater, at 2.1%, which is around 8% of total benefits expenditure.[26] Disability benefits expenditure has increased by 18.6% since 2000 within the EU25 (Figure 2).

[25] OECD, *Transforming disability into ability*, Paris, OECD, 2003, available online at: **http://www.oecd.org/document/14/0,3343,en_2649_34747_35290126_1_1_1_1,00.html**.

[26] Eurostat, *Social protection – Expenditure and receipts Data 1997–2005*, 2008 edition, European social statistics, Luxembourg, Office for Official Publications of the European Communities, 2008, available online at: **http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-DC-08-001/EN/KS-DC-08-001-EN.PDF**.

Figure 2: *Increase in social protection expenditure on disability, EU25 (millions of €)*



Source: *Extracted from Eurostat, 2008 (see footnote 26)*

These facts should be viewed in relation to the finding that employment among persons with health problems or disabilities has not increased and in some cases has fallen when compared with other groups – even in the context of strong economic growth and a greater emphasis on employment integration and anti-discrimination measures.[27] In addition, levels of unemployment among people with health problems or disabilities are typically twice as high as for those without disability. Furthermore, the relative financial position of disabled persons has declined in the past decade.

In the currently poor economic climate, reduced work capacity has the potential to make a person less competitive as a jobseeker in a labour market with fewer work opportunities. The medically driven models used to determine disability benefit entitlements have been demonstrated to be unreliable in predicting return to work. This results in disabled people with residual work capacity being deemed unable to work.

The EU and the Member States have been addressing the challenge of raising employment rates for persons with disabilities for many decades through the implementation of programmes, the development of policies and the introduction of mechanisms to promote and enhance the labour market participation rate. It is acknowledged that equivalent employment rates for disabled persons and people without disability have not been achieved and that it is essential that people with disabilities are better integrated into the labour market if the employment targets set in the renewed Lisbon Strategy are to be reached.

Central to the EU approach to disability is encouraging economic activity and employment through:

- the full implementation of Council Directive 2000/78/EC[28] establishing a general framework for equal treatment in employment and occupation, known as the Employment Equality Directive;
- mainstreaming disability into the European Employment Strategy[29] through the open method of coordination (OMC);
- focusing the ESF on active inclusion and pathways to re-entry to employment for people who lost their job as a result of disability.

[27] OECD, *Sickness, disability and work: Keeping on track in the economic downturn*, Background paper, High-Level Forum, Stockholm, 14–15 May 2009, available online at: **http://www.oecd.org/site/0,3407,en_21571361_42464611_1_1_1_1_1,00.html**.

[28] **http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32000L0078:EN:HTML**.

[29] **http://ec.europa.eu/social/main.jsp?catId=101&langId=en**.

The employment of people with disabilities is central to the EU Disability Action Plan 2008–2009 and to the Employment Guidelines (2008–2010) within the European Employment Strategy. For example, Guideline 18 includes a specific reference to disabled people.[30] Moreover, the ESF Regulations 2007–2013 include a requirement for accessibility on the part of co-financed measures, specific actions for social inclusion, promoting pathways to integration and re-entry into employment, diversity and combating discrimination in the workplace. In addition, a wide range of actions are covered, including rehabilitation, job creation in the social economy, support to promote the entrepreneurship of disabled people and awareness-raising campaigns to combat discrimination.

Numerous interventions were implemented during the 2000–2006 ESF programming period to achieve a more inclusive labour market. These included:

- subsidising jobs to facilitate integration in the open labour market;
- assistance to obtain a job with the support of specialised organisations;
- employment incentives that allowed access to a sustainable job;
- implementing inclusion pathways and promoting self-employment;
- improving employability through vocational training programmes that allowed the improvement of basic skills, professional rehabilitation and orientation.

The Employment Guidelines state that attention should be paid to the situation of young people, implementing the European Youth Pact.[31] The guidelines highlight that it is important to promote access to employment throughout working life and to significantly reduce employment gaps for people at a disadvantage, including disabled people. The most relevant actions specified within the guidelines include:

- attracting and retaining more people in employment, modernising social protection systems and fostering better education and skills (Guideline 17);
- building employment pathways, breaking down barriers to the labour market by assisting with effective job searching, facilitating access to training and other active labour market measures, ensuring that work pays and removing unemployment, poverty and inactivity traps (Guideline 18);
- ensuring early identification of needs, offering job search assistance, guidance and training through personalised action plans, and providing the necessary social services to support the inclusion of those most distant from the labour market (Guideline 19);
- modernising and strengthening labour market institutions, notably employment services (Guideline 20);
- devising inclusive education and training policies, facilitating access to initial vocational, secondary and higher education, and ensuring efficient lifelong learning strategies (Guideline 23).

[30] **http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2008:198:0047:0054:EN:PDF**.

[31] **http://europa.eu/legislation_summaries/education_training_youth/youth/c11081_en.htm**.

The Joint Report on Social Protection and Social Inclusion 2007 outlined the range of active inclusion measures to promote the social and labour market integration of people most distant from the labour market.[32] A major component is increasing the conditionality of benefits, that is, making active job search a criterion of eligibility. However, the report warns that this approach must not push people who are unable to work further into social exclusion. This requires a balanced approach combining personalised labour market support, including skills training, and accessible, high-quality social services.

With regard to one of the primary pillars of the European Disability Strategy (2004–2010) – which is to mainstream disability into all policy areas – the report notes that mainstreaming remains limited. Employment activation, eliminating barriers to education and lifelong learning, and stricter conditionality generally dominate as mechanisms to promote the inclusion of disabled people rather than the elimination of structural obstacles to full participation. In particular, the report recommends vigilance when it comes to new risk groups such as young workers and labour market entrants.

The European Commission Recommendation (2008) on the active inclusion of people excluded from the labour market[33] sets out the agenda that needs to be followed in clear and simple terms. At the core of the approach are the principles of fundamental rights, gender equality and equal opportunities for all. The Commission acknowledges the complexities of multiple disadvantages and the specific situations and needs of the various vulnerable groups. It also takes account of the local and regional context and the need to adopt a life-cycle approach to social and employment policies so that they can support intergenerational solidarity and break the intergenerational transmission of poverty. The final principle makes it clear that young people with health problems should be a central priority in the active inclusion agenda.

The implementation of active inclusion policies must be based on recognition of the individual's right to adequate income support that respects their dignity and right to a minimum standard of living. However, this strategy should be combined with the availability of work or vocational training and be underpinned by national policies. In parallel, the operation of an inclusive labour market must include conditions that help people who are fit for work to enter or re-enter and remain in appropriate employment. This requires measures that address the needs of people who are excluded from the labour market, based on the principles that access to quality jobs, lifelong learning and job retention should be an opportunity open for all. Lifelong learning is often taken to be most relevant to older and low-skilled workers. However, in the context of a life-cycle approach to inclusion, it should also be understood to refer to young people with health problems, who in many cases leave compulsory education with fewer skills and lower qualifications than their peers.

The practical application of the inclusive labour market approach depends on changes to education and training policies – including lifelong strategies – and systems, particularly in relation to new skill requirements. This needs to be complemented by customised, individualised, responsive services and supports for the early identification of needs, job search assistance, guidance, training and encouragement. A systems approach implies the removal of barriers and disincentives to employment, including those arising from tax and benefit systems, while ensuring adequate levels of social protection.

[32] European Commission, Directorate-General for Employment, Social Affairs and Equal Opportunities, *Joint report on social protection and social inclusion 2007: Social inclusion, pensions, healthcare and long-term care*, Luxembourg, Office for Official Publications of the European Communities, 2007, available online at: **http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2007/joint_report_en.pdf**.

[33] European Commission, Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions, *Commission Recommendation on the active inclusion of people excluded from the labour market*, COM(2008) 639 final, Brussels, 3 October 2008, available online at: **http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2008:0639:FIN:EN:HTML**.

An active inclusion strategy can involve a varied set of opportunities and support in addition to the more traditional approaches. These include social economy initiatives and/or sheltered employment, microloans, financial incentives for employers to recruit, job creation particularly at local level and awareness-raising measures. The use of sheltered employment implies that it can develop and maintain skills and work-related social competence for people who are currently outside the labour market. However, the transition from sheltered employment to the open labour market is not without its own challenges. Many young people with disabilities have traditionally entered the protected labour market but relatively few have progressed to employment on the open labour market. A potentially more influential active strategy is based on the SE model in which people with disabilities are placed in jobs within normal workplaces in order to train them rather than in sheltered work environments.

The active inclusion strategy is predicated on the assumption that the services that are needed to support it are actually available and of good quality. In the case of young people with health problems, they must also be accessible.

There is strong evidence that most Member States have active inclusion among their priorities. The main challenge arises from the separate implementation of inclusive labour market mechanisms, access to quality services and adequate income. Given that young people with health problems suffer from multiple disadvantages, they require a more integrated set of responses. Nevertheless, many Member States continue to improve active inclusion policies by strengthening their focus and upgrading system incentives for activation.

While not targeted specifically at young people, many active inclusion measures to counter labour market exclusion due to disability are relevant to their needs. These include rehabilitation, measures to prevent work-related disabilities and accidents, as well as incentives for employers to recruit people with disabilities. Some of these measures include: a new rehabilitation benefit for persons in search of work (introduced in Hungary); more integrated rehabilitation systems with stricter time frames for assessing work capacity (Sweden); placing more responsibility on employers and workers for rehabilitation (the Netherlands); and reforms to disability and invalidity systems (for example, in the UK). Other approaches include focusing on work-related and depression-related disabilities (Denmark and Finland) by promoting mental well-being at work through targeted prevention, treatment and rehabilitation. Many approaches involve employers and health professionals in follow-up activities for people on sick leave (for example, in Denmark and Norway). One way of doing this is to introduce experience rated insurance payments to incentivise employers to focus more effectively on prevention (Belgium). Finally, many EU Member States operate a quota system that requires employers to employ a certain proportion of disabled workers and these systems are being reviewed to try to target them more effectively.

The growing attention to tertiary prevention – that is, putting mechanisms in place to address unemployed or long-term absent people with disabilities – has resulted in less focus being placed on young people with special educational needs, impairments and health difficulties who have never had the chance of entering the workforce. This lack of emphasis is evident at Member State and EU levels in the lack of specific attention paid to young people with disabilities in many social inclusion and active inclusion position papers, and in the social security and social protection systems of the Member States. While older workers and economically inactive persons are often the target of policies and interventions, the challenges facing young people with health problems have a much lower profile.

The issues facing young people in general are clearly a priority. It is recognised that young people between the ages of 15 and 29 years represented almost 40% of the total unemployed population in the EU in 2006, and the European Employment Strategy and national employment action plans of the Member States have addressed the employability of young people from the outset. Equally, the challenges facing people with disabilities in gaining meaningful employment are clearly set out in the European Disability Strategy 2004–2010 and the current Disability Action Plan 2008–2009.

What seems to be absent from the debate and relatively unsupported by the principles outlined is the situation of young people with disabilities who are embarking on working life for the first time or who have experienced health problems while at work.

Factors determining participation in working life

Many factors operate to facilitate or inhibit a successful transition to active working life. Some of these arise from the personal characteristics of the individual in terms of their maturity, gender, educational level, aspirations, previous life experience, social and economic status, beliefs and coping strategies. Environmental factors also play a major role, including the:

- supports and services provided by the school;
- constraints and opportunities inherent in regulatory and administrative systems;
- supports and relationships available from family, peers, individuals, teachers and other professionals, such as career guidance professionals, and their attitudes;
- environment within which the progression is taking place – for example, an urban or rural location;
- materials, technological tools and other products available to the individual, such as their own car.

These personal and social factors can interact with the person's innate and developed capacities, talents and other attributes, and their competence in dealing with life activities such as communicating, forming and maintaining relationships, reading and writing, study skills, time management and taking care of themselves independently. All of these factors can come together to enhance or inhibit a successful transition.

In order to gain a coherent overview of the way in which these factors interact in the case of young people with health problems or disabilities, a framework has been developed which provides an indication of the transition process at four levels – personal, system, employer and economic.

Personal factors

Personal factors relate to the capacities of the individual to work and to the nature of any physical or mental impairment that they may have. In addition, they refer to the level of motivation of the individual in seeking and obtaining a job. Factors relating to the person include age, ethnicity, level of education, motivation and expectations. Being young creates significant challenges for anyone trying to access employment and these are compounded in the case of young people with disabilities. Many of these challenges result from increasing unemployment rates for young people in many Member States. In addition, young people lack many work-related assets that can be useful in accessing the labour market, such as a proven track record in employment, work experience, established work habits, and job getting and keeping skills.

The dynamic interaction between young people with health problems and the environment – including the family – can shape their view of the world and how they relate to it. Growing up with a functional impairment can result in a person being disempowered in their choices and learning to be dependent on others. The challenge for young people who develop or acquire a health condition either before they have work or while in employment can fundamentally impact on their personality, their hopes and beliefs and their aspirations. In the absence of early intervention for young people with health problems, the likelihood of long-term dependency and disability is greatly increased.

The employability of young people with health problems can also be influenced by their health behaviour and lifestyle. In particular, substance misuse can have a strong bearing on whether a young person is motivated and prepared to enter employment.

Functioning and health

Young people with health problems are a heterogeneous group in terms of individual differences. Health difficulties can arise at birth and result in physical, sensory, intellectual and neurological impairments which can be stable, chronic or progressive. Other difficulties emerge as a result of developmental factors and become manifest in communication difficulties and social, emotional or behavioural difficulties during the early school years. Some of these have increased in frequency in recent years with better diagnostic procedures and changing eligibility criteria for learning supports and resources. This is particularly so for Autism Spectrum Disorder (ASD) and Attention Deficit and Hyperactivity Disorder (ADHD).

By linking educational resources to diagnostic categories, some special education systems create incentives for parents to acquire such diagnoses in order to access supports and interventions. Some conditions only emerge during adolescence. Many of these have a mental health dimension and include early onset psychotic conditions, depression and anxiety. If not treated appropriately, these can result in the development of lifelong chronic conditions which interfere with the social and economic status of the person. Emotional and behavioural difficulties continue to emerge during third-level education and can have an equally negative impact. While acquired physical or neurological impairments are relatively rare during childhood and adolescence, they increase substantially in early adulthood, with the majority of cases of traumatic brain injury occurring in people under 25 years old.

The increase in the number of young people being diagnosed with mental health problems is of particular concern. An enquiry to the EU Member States issued by Eurofound in November 2008 resulted in 12 countries reporting an increase in people with mental health difficulties taking up disability benefits. The data presented in Table 5 (p.19) support these impressions even though the figures vary widely and range from about 60% or more in Denmark, Finland, the Netherlands, Norway, Switzerland and the UK to less than 30% in Luxembourg, Poland and Spain.

It is difficult to relate these increases directly to population data. One reason for this is the way in which mental health problems are documented in Eurostat surveys, where intellectual impairment is associated with mental, nervous or emotional problems. Nevertheless, an abstract of disability data from Eurostat (Table 6 on p.20) indicates that self-reported mental disabilities represent less than 10% of all long-standing health problems and disabilities. For young people between the ages of 16 and 24 years, this figure is 12%. It is unlikely that a rise in mental health conditions among young people can account on its own for the very large increases in the take-up of disability schemes reported by Member States.

For example, in the Netherlands, 80% of the inflow to the Wajong scheme can be attributed to mental disorders, behavioural problems and diseases such as autism and ADHD. In Denmark, mental health problems constitute 40% of all the causes in the take-up of disability benefits. Finland also reports a significant increase in mentally related incapacity beneficiaries; 40% of all disabled people suffer mental problems. This proportion is even higher among young people: 70% of the young people on incapacity benefits are classified as having mental health problems. This increase is especially marked among young women.

One in 10 children in the UK aged 5–16 years had a clinically recognisable mental disorder in 2004. This was the same as the proportion recorded in a 1999 survey. In 2004, 4% of children had an emotional disorder such as anxiety or depression, 6% had a conduct disorder, 2% had a hyperkinetic disorder and 1% had a less common disorder, including autism, tics, eating disorders and selective mutism. Some 2% of children had more than one type of disorder.

Table 5: *Mental ill-health among benefit claimants*

	Year	Type of indicator	Comparator	Age group	%	Source
CH	2004	Persons with mental ill-health taking up benefits	All claimants with disabilities	20–34	70	Disability insurance (*Invalidenversicherung*, IV)
DK	2004	Persons with mental ill-health taking up benefits	All claimants with disabilities	20–34	70+	National Social Appeals Board, Danish Ministry of the Interior and Social Affairs (*Indenrigs- og Socialministeriet*)
ES	2004	Persons with mental ill-health taking up benefits	Sample of claimants with disabilities	20–34	13.8	University of Madrid, based on linked data from the National Institute of Social Security (*Instituto Nacional de la Seguridad Social*, INSS) and the Institute for Older People and Social Services (*Instituto de Mayores y Servicios Sociales*, IMSERSO)
FI	2004	Persons with mental ill-health taking up benefits	All claimants with disabilities	20–34	70	Finnish Centre for Pensions (*Eläketurvakeskus*, ETK)
LU	2004	Persons with mental ill-health taking up benefits	All claimants with disabilities	20–34	26.7	General Social Security Inspectorate (*Inspection générale de la sécurité sociale*, IGSS)
NL	Not specified	Persons with mental ill-health taking up benefits	All claimants	Young people	Substantial increase	Not specified
NL	2007	Persons with mental ill-health taking up benefits	All claimants with disabilities	20–34	65+	Institute for Employee Insurance (*Uitvoeringsinstituut Werknemers Verzekering*, UWV)
NO	2004	Persons with mental ill-health taking up benefits	All claimants with disabilities	16–34	65+	Norwegian National Insurance Administration (NIA)
NO	2006?	Persons with mental ill-health taking up benefits	All claimants	Young people	50+	Brage, S. and Thune, O., *Medisinske årsaker til uføreytelser blant unge 1977–2006*, Norwegian Labour and Welfare Organisation (*Norsk Arbeids- og velferdsetaten*, NAV) report 3/08
PL	2004	Persons with mental ill-health	All disabled people	15–19	13.2	Health of Polish population in 2004 (*Stan zdrowia ludności Polski w 2004 r.*)
PL	2004	Persons with mental ill-health taking up benefits	All claimants with disabilities	20–34	30	Social Insurance Institution (*Zakład Ubezpieczeń Społecznych*, ZUS)
UK	2006	Persons with mental ill-health and learning disabilities taking up benefits	Sample of claimants with disabilities	20–34	58.9	DWP Work and Pensions Longitudinal Study (WPLS)

Table 6: *Age and type of disability, EU25 (%)*

Age	Physical	Sensory	Mental	Progressive	Other	No response
Total	72.5	6.6	9.3	3.3	7	0.5
16–24 years	65.4	9.9	12	1.4	11	0.2
25–34 years	65.4	8.2	13.9	2.3	9.9	0.3
35–44 years	68.7	6.2	12.4	3.2	9	0.5
45–54 years	73.5	6.3	8.5	3.7	7	0.6
55–64 years	79	5.4	5.2	4	5.9	0.5

Source: *Adapted from Eurostat* Percentual distribution of types of disability by sex and age group.[34] *Update 9 August 2009*

The profile of disability benefit claimants in the UK provides a different picture – it has changed substantially during the past decade. As noted earlier, compared with 10 to 15 years ago, the recipient today is more likely to be a young person, a woman, a recipient of a non-contributory benefit due to a limited work history and, most importantly, a person with a mental or behavioural health condition. Table 7 provides a comparison of the number of disability claimants in May 2002 and in February 2009. This illustrates the increase in younger disability claimants over the period. In addition, according to at least one regional survey, mental health difficulties account for up to 40% of the beneficiary population, and their proportion continues to rise.[35]

Table 7: *Increase in UK disability claimants (all benefits), 2002–2009*

	May 2002 (000s)	February 2009 (000s)	% increase
Under 5 years	42.2	43.48	3.03
5 to under 11 years	116	129	11.21
11 to under 16 years	95.33	142.2	49.17
16–17 years	19	43.75	130.26
18–24 years	19.98	44.72	123.82
25–29 years	11.73	18.28	55.84

Note: *Data accessed 11 September 2009.*
Source: *DWP, Research and statistics*

This suggests that there has been a great increase in the number of children in the UK with disabilities associated with psychological and mental problems. The extent to which this figure is attributable to a better diagnosis of cases is debatable.

In Poland, among disabled persons aged 15–19 years, the greatest category of disabilities comprised various forms of motor impairment, followed by sight impairment and by neurological disorders. The other major categories of disability included mental impairment, psychological and emotional problems, hearing impairment and cardiovascular problems.[36]

[34] **http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/dataset?p_product_code=HLTH_DB_EMTYAG**.

[35] West Midlands Region – Pen Picture, Job Centre Plus, 2008, **http://www.jobcentreplus.gov.uk/JCP/static/Dev_005595.pdf**.

[36] Given that the previous studies from 1996 employed a different method for aggregating data, it would be difficult to assess any changes in the disability categories.

In Norway, more than half of the young people on disability pension have some type of psychological or emotional dysfunction. Psychological dysfunctions are overrepresented among disabled persons who have been granted the 'young disabled' supplement to their benefit, that is, persons who have been granted disability pensions while very young. It also seems as if there has been a change in the type of psychological or emotional dysfunction among new entrants, particularly in relation to the higher number of persons diagnosed with personality disorders as well as problems related to the abuse of drugs and depression.[37]

In Spain, although the number of disabled young people is stable, the proportion of those with mental problems has increased significantly. For example, in 1999, 39.5% of disabled 6–16 year olds experienced difficulties in the category 'to learn, apply knowledge and development of tasks', while in 2008 this proportion rose to 53.9%.

Another indication of the increasing prevalence of mental health difficulties among young people with disabilities is the pattern of admissions into vocational training centres (*Berufsbildungswerken*, BBW) in Germany; these centres provide vocational rehabilitation and training to young people. While the data are incomplete, the upward trends in both mental health conditions in general and in ADHD in particular are evident (Table 8).

Table 8: *Intake into BBW in Germany, 2004–2007*

	Intake*	Mental health problems	%	ADHD	%
2004			36.8		
2005	2,302	1,006	43.7		
2006	6,652	2,966	44.6	517	7.8
2007	6,934	2,928	42.2	721	10.4

Note: **2004 and 2005 figures refer to pre-vocational training only.*

The increase in mental health conditions could also be related to the higher detection of such diseases – in particular depression and ADHD – than in the past, as there are more doctors and specialists who can assess mental conditions. In addition, less stigma may now be attached to such disorders.

Each of these conditions has its own potential trajectory in relation to transition to adult life and work. They require the type of customised, individualised, responsive services and supports for the early identification of needs, job search assistance, guidance, training and encouragement that are described in the 2008 European Commission Recommendation on the active inclusion of people excluded from the labour market (see previous chapter).

The dynamic interaction between young people with health problems or disabilities and the environment in which they grow up can result in a number of personal characteristics that can enhance or inhibit their work-related assets. In addition to mobility difficulties, these can include limitations in many key areas of independent living such as learning and applying knowledge, self-care, communications and managing interpersonal relationships with family, peers and strangers. These challenges are strongly related to autism, ADHD and behavioural difficulties.

[37] Brage, S. and Thune, O., *Medisinske årsaker til uføreytelser blant unge 1977–2006*, NAV report 3/08, available online at: **http://www.nav.no/binary?id=229510&download=true**.

Furthermore, it has been well documented that people with disabilities emerging from full-time education tend to lack the skills and experience required to compete effectively in the labour market. They also generally have lower qualifications then their non-disabled peers. The early school leaving rate of students with disabilities is significantly higher and opportunities for them in the mainstream system are limited. As a result, they often move into the specialised disability services sector looking for the support and interventions that they require, despite having progressed through their school careers in mainstream settings.[38] Access to services often requires a disability pension to achieve eligibility and this is another factor in motivating young people with health problems to gain access to social protection. There is also evidence of a strong link between the increasing Wajong recipient population in the Netherlands and the growing number of children receiving special education in special schools (a 21% increase in the period 2003–2006).[39]

System factors

System factors are of two kinds. Structural factors refer to the set of policies, legislation and benefits that apply to young people with disabilities, while process factors refer to the services which are available to support people in finding a job and to the interactions between them, the individual and the prospective employer. Also important are the services and incentives which might support the employer in recruiting and retaining a person with disabilities.

Current systems designed to respond to the needs of young people with disabilities have been developed over many years and contain many 'legacy' elements which conspire to institutionalise people with disabilities. While mainstreaming and non-discrimination have been basic principles of the European Disability Strategy for more than a decade, it is not hard to find system elements and approaches in most Member States which predate the Amsterdam Treaty, effective from May 1999, and which can be seen as barriers to full social inclusion rather than solutions to the problem. Special institutes providing vocational education and training for people with disabilities exist in most Member States and in some cases comprise the majority of labour market focused services. Special education provisions in a number of Member States are still based on segregated and special schools, at least for some types of impairments. Very often these schools do not provide access for students to the mainstream curriculum and as a result the young people are further disadvantaged in the labour market. Many providers offer lifespan services and thus operate sheltered workshops or sheltered employment facilities into which many of their service users progress on completing education. Breaking the cycle of institutionalisation and raising the expectations of young people with health problems and their families requires new thinking and the development of more innovative approaches which bring together the expertise of the specialised providers within a customised mainstream context.

It is important to note that the problems experienced by young people are located not only in the education systems, which are less than effective in preparing them to compete effectively in the labour market. Many disability benefits schemes and services – which traditionally dealt with primarily chronic, physical conditions – are being challenged by the increase in participants with mental health and behavioural difficulties, as evidenced for example in the changing profile of entrants into the German BBW systems. This requires a rethink of the approaches and methodologies adopted in terms of determining eligibility, needs and rehabilitation strategies. Mainstream employment and social protection systems are also less than responsive to the complex and multi-dimensional needs of young people with health problems.

[38] National Disability Authority, *A strategy of engagement: Towards a comprehensive employment strategy for people with disabilities*, Executive summary, Dublin, 2006, available online at: **http://www.nda.ie/cntmgmtnew.nsf/0/A85B41AE9B9BD322802572BA00508B19/$File/stratexec.htm**.

[39] Besseling, J. et al, *Toenmame gebruik ondersteuning voor jongeren met een gezondheidsbeperking*, Hoofddorp, TNO, March 2007, cited in Schoonheim and Smits, 2007, available online at: **http://www.tno.nl/downloads/KvL-APAR-129_2007_3_10949.pdf**.

In addition, a gap operates between the education system, which has been supporting the person for most of their early life, and the employment and social protection systems which have responsibility to provide appropriate supports and interventions to them as young adults. Even where Individual Transition Planning is mandated by legislation – for example, in Ireland and the US – it is rare for a representative of employment or social protection services to actually attend a transition planning meeting. A similar gap exists between sheltered employment services and the open labour market.

As a result, the young person can lose their entitlement to the supports, aids and interventions to which they have become accustomed and it often takes many months before these are replaced. An example of this is where the education system is subsidising accessible transport for a person to attend school, but no similar grants are available under employment or social protection provisions. As a result, a young person can be confined to their family home for an extended period or the parents must absorb the expense.

The requirement to develop a transition plan is rare in Member State legal systems. In the absence of such support, the transition to adulthood and work becomes a major challenge for the families of the young person, who must try to patch together a support plan using their own financial, emotional and persuasive resources. Given the enormity of this challenge, it is not surprising that many young people and their parents opt to gain access to special facilities and consequently the social protection system.

It is important that, as young people mature and develop, they can establish a life that is independent of their family. A crucial aspect of this is having an independent source of income. In recognition of this, most Member State social protection systems provide a disability-related income support to young people when they reach a certain age – usually 18 years. In essence, this involves changing from supports that are allocated to the family during the childhood years to income support for the person. As a result, the young people concerned are often automatically registered into the social protection system.

Clearly, it is important to provide a basic income to young adults with disabilities, but this must be balanced with active measures to encourage them to progress to earned income opportunities. The young people concerned have usually never experienced having their own income until they begin to receive the disability pension and, because many of their needs and expenses are covered by their families, they find themselves for the first time with disposable income. This can act as a de-motivator to take up opportunities which may result in the loss of such income. In some Member States – for example, in Austria, Finland and Germany – the principle of 'rehabilitation before pension' operates. It may well be worth extending this principle to vocational education and training for young people with health problems.

Tables 9 and 10 provide an analysis of current social protection approaches using a Policy Analysis Tool developed to document the inhibitors and enhancers of job retention for ill or injured absent workers.[40] Each measure has been reviewed in terms of:

- what it is intended to do – for example, to maintain a person's income, promote health or promote employment;
- which element of the labour force it is intended for – for instance, people who are at work, unemployed persons, economically inactive people or long-term absent individuals;
- which groups are the intended recipients or beneficiaries of the measure – for example, those at risk of exclusion, discrimination or unemployment, disabled people or the labour force in general;

[40] Wynne and McAnaney, 2004 – see footnote 1.

- how it sets out to achieve its intended impact – for instance, as a policy measure, as an intervention at the level of the individual or workplace, or as an incentive system;
- who has responsibility for putting it into practice – for example, the employer or an agency external to the workplace.

In this regard, it is interesting to note that the majority of social protection measures available to young people with health problems aimed either to compensate for the cost of disability (Table 9) or to provide income maintenance (Table 10).

Table 9: *Compensation for costs for young people with disabilities*

Type of measure	Labour market status		Intended beneficiary	Eligibility criteria	Measure
Individual support	Inactive	**BE**	Family	1. Child with physical or mental disability 2. 66% incapacity 3. Under 21 years	Supplementary Family Allowance
		FI	Individual	1. Requiring care in excess of normal needs 2. Under 16 years	Family Allowance
		FR	Family	1. Permanent disability 2. 80% incapacity 3. Under 20 years	Special Education Allowance
		IE	Family	1. Requiring care in excess of normal needs 2. Residing at home 3. Under 16 years	Domiciliary Care Allowance
		LU	Family or individual	1. Inability to provide for own needs or 2. Under 18 years	National Family Allowances Fund
		NL	Family	1. Being assessed as having an impairment 2. Aged 3–17 years	Child Benefit for Disabled Children
		PT	Family	1. Requiring special education or interventions 2. Under 24 years	Family Allowance

Source: *Extracted from Eurofound background report, 2009*

Table 10: *Income maintenance for young people with disabilities*

Type of measure		Labour market status	Intended beneficiary	Eligibility criteria	Measure
Individual support	**AT**	Inactive	Family	1. Incapacity to work 2. Under 21 years or 3. Under 27 years if in vocational training	Child Benefit
	FI	Inactive	Individual	1. Incapacity to work 2. Three years' residency 3. Aged 21–65 years 4. No qualifying period if aged 16–21 years	Incapacity Benefit
	LT	Unemployed	Individual	1. Physical or mental impairment 2. Incapacity to work 3. Under 20 years	Incapacity Benefit
	NL	Inactive	Individual	1. Incapacity to work 2. Being a resident 3. On reaching 18 years or 4. Acquiring a condition during education or vocational training	Assistance Act of Young Persons
	NO	Not relevant	Individual	1. Clearly documented serious and permanent condition 2. Under 26 years 3. Non-means tested	Social protection
	PL	Not relevant	Individual	1. Disability occurring before 18 years or during education	Social protection
	UK	Inactive	Individual	1. Incapacity to work for at least 28 weeks 2. Aged 18–20 years or 3. Under 25 years in education or vocational training	Incapacity Benefit

Source: *Extracted from Eurofound background report, 2009*

Table 11: *Social protection measures for young people with disabilities – Individual supports and incentives*

	Purpose	Type of measure	Status	Intended beneficiary	Eligibility criteria	Responsible actor
BE	Integration in employment	Financial and non-financial assistance	Inactive or unemployed	Young persons	1. Not ready to work 2. Physical and intellectual impairment	Public social welfare centres
DE	Positive action and protection	Coordinating mechanisms	People in difficult social circumstances	Individual	1. Low or no qualifications 2. Family circumstances 3. Poor health 4. National origin	Welfare organisations
DK	Integration in education and employment	Financial and non-financial assistance	Economically inactive	Individual	1. Early school leaver 2. Ethnic minority 3. Children at risk 4. Socially excluded	
IE	Positive action	Coordinating mechanisms	Disabled	Individual and environment	1. Long-term disability	State
IT	Income support	Anti-poverty	Households	Individual	1. Low employment and income opportunities	Municipality
LU	Wage subsidy	Incentive	Employed	Individual	1. Working age with a disability	
SI	Prevention of social deprivation	Social assistance and employment support	In need of support	Individual	1. Disability 2. Low income 3. Means tested	Public department in field of social welfare
UK	Social care	Direct payments	Assessed need for care	Individual	1. Disabled adult 2. Family of children with disabilities 3. Older person	Social services
All	Anti-discrimination	Equality	Jobseeker or worker	Individual and environment	1. Discriminated against 2. Disability	

In response to the European Commission's consultation on active inclusion[41], a number of Member States responded by outlining what they believed were the most relevant measures within their own jurisdictions. These are presented in Table 11 along with other active measures identified through consultation with independent experts. A number of interesting approaches can be identified which could have particular relevance to young people with health problems. These include the direct payments approach in the UK where local authorities and funding agencies are required to offer the individual who has been assessed as eligible for social services – or their family – a personal budget to purchase the

[41] European Commission, Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions, *Concerning a consultation on action at EU level to promote the active inclusion of the people furthest from the labour market*, COM(2006) 44 final, Brussels, 8 February 2006, available online at: **http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2006:0044:FIN:EN:HTML**.

services required rather than making a referral to a particular service. In the Netherlands, where this approach also operates for employers and workers to develop return to work plans, this system has been demonstrated to result in more sustainable positive outcomes.

Where there is an issue about the capacity of the individual to manage their own funding, a facility is available to establish a 'mini board' of interested parties chosen by the person, including advocates and family members. A similar scheme operates in Denmark in which people with disabilities who commit to enter employment are provided with funds to employ their own personal assistants.

Another interesting approach is that adopted in Ireland where, under the Disability Act 2005, pre-school children and adults over 18 years with significant and long-term disabilities have the right to an assessment of their health and social care needs and a statement of the services that they require which can be used to create a service plan. Younger people with disabilities of school-going age are covered by a complementary measure which guarantees an assessment of need and an individual educational plan. Under the same Act, a number of government departments with responsibility for disability – including Health and Children; Enterprise, Trade and Employment; Social and Family Affairs; Communications, Energy and Natural Resources; and the Environment, Heritage and Local Government – are required to create action plans to provide more responsive and accessible facilities and services for people with disabilities.

All EU Member States have introduced non-discrimination measures which are designed to protect people with disabilities from discrimination in vocational training, recruitment procedures of employers, accessing career development opportunities and job retention. Disabilities arising from mental health difficulties are also covered by such legislation. Alongside active measures such as job coaching, rehabilitation and case management, equality legislation can enhance the chances of a person with a disability getting a job. However, non-discrimination legislation prohibits discrimination on the grounds of disabilities; it may not protect a young person on the grounds that they lack the experience or qualifications to carry out the responsibilities of a job.

While the legal mechanisms to support active inclusion are essential in providing a framework for action, many other system factors can operate to inhibit or enhance the labour market participation of young people with health problems.

Structural factors

Structural factors refer to systems features that operate in parallel without connecting with each other, but which each have an impact on the lives of people with disabilities. For example, in the event that an individual acquires or develops a functional impairment, it is likely that health, social protection and employment services will be required. Equally, environmental adaptations or assistive technologies may be necessary. When these systems operate, the onus is usually on the disabled person or their family to try to bring all the required inputs together. In some initiatives, case managers have been introduced to assist the person in accessing the services and supports that they need in a timely manner.

Many systems operate on the basis of default strategies and eligibility criteria. Strategies and interventions evolve over time rather than being designed from first principles and often address broad categories of disabilities. In this context, individual differences are less important than establishing whether a person 'fits' in a particular category for funding purposes. This is particularly the case in systems in which diagnostic categories are used as the basis for determining eligibility. The most often applied categories are physical, sensory, mental health and intellectual disabilities. In such a system, people with a dual diagnosis – for example, a physical and mental health condition – find it very difficult to access appropriate services. A similar difficulty faces people with neurological conditions, including acquired brain injury, which can have physical, sensory, mental and intellectual components.

An important element of a flexicurity approach is the modernisation of the social security system. An implication of this is that passive social protection measures need to be replaced or complemented by active measures. Passive social protection tends to concentrate on income maintenance rather than activation. This results, on the one hand, in the application of relatively strict eligibility criteria for access to benefits, which can mean that many people with moderate impairments are excluded. On the other hand, this passive approach often creates a 'benefits trap' that makes it very difficult for a person to make the transition from benefits to employment, resulting in low outflows from the pension system.

It is well accepted that negative attitudes to people with disabilities and the stigma associated with being labelled as disabled represent major barriers to cultural, economic, political and social participation. This is well represented in the ICF, which specifies the attitudes of family members, health and other professionals, people in positions of authority and wider society – as well as societal norms and practices – as key factors influencing the participation of people with disabilities. The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)[42] requires state parties to:

- raise awareness throughout society, including at family level, regarding persons with disabilities;
- foster respect for the rights and dignity of persons with disabilities;
- combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life;
- promote awareness of the capabilities and contributions of persons with disabilities.

The measures to achieve these objectives include:

- organising effective public awareness campaigns;
- fostering at all levels of the education system, including in all children from an early age, an attitude of respect for the rights of persons with disabilities;
- encouraging all organs of the media to portray persons with disabilities in a manner consistent with the purpose of the present Convention;
- promoting training programmes regarding persons with disabilities and their rights.

Process factors

In addition to the structural factors that can impact on the social inclusion of young people with disabilities, a number of process factors can also be identified. These include the expectations of the families of young people with disabilities, which can undermine the motivation of young people seeking work. In a study of the barriers facing jobseekers with disabilities in accessing the labour market, focus groups were carried out in 13 countries.[43] The impact of family expectations on the decision to look for work was a consistent theme in the feedback from the focus groups.

[42] **http://www.un.org/disabilities/convention/conventionfull.shtml**.

[43] Opti-Work (Optimising strategies for integrating people with disabilities into work), **http://www.optiwork.org**.

In the transition from education to the labour market, from sheltered to open employment or from economic inactivity to jobseeking, a number of other process factors can operate as barriers to inclusion. A particular challenge is created by discontinuities between systems, especially between health, education, labour and social protection. While many active measures, supports and interventions may be available to a person within a system, these are often lost when a person makes the transition to another system. While this problem has been described earlier in relation to the transition from school to work, similar discontinuities exist when moving from social protection to employment in terms of the loss of services, supports and secondary benefits such as free travel or rent allowance.

Even in the event that sufficient resources are allocated to services for people with disabilities, two other process factors operate. The first is a lack of appropriately trained staff within the health, employment, education and social protection systems. A recurring theme in the UNCRPD is the requirement to provide training for professionals in all areas relevant to people with disabilities. The second issue is that, although it is widely accepted that the provision of transition services is required for people moving from one system to another, this necessitates allocating resources from more than one statutory agency's budget. This requirement represents a major administrative barrier to the development of such services not least because of a suspicion on the part of authorities that it will result in 'double' funding – that is, paying twice for the same services.

Employer factors

Another domain of influence on the inclusion of young people with health problems is the workplace and, in particular, the role that employers and trade unions[44] can play in creating a more inclusive workplace. Workplace factors are often relatively neglected in discussions about the employment of people with disabilities. During the Opti-Work study (see above), employers in the 13 participating countries were asked to describe the challenges that they faced in recruiting people with disabilities. The feedback revealed that, even when an employer is motivated to hire a jobseeker with a disability, accessing the necessary supports and interventions to make this happen was a major challenge.

If this is the case for an employer who is proactively seeking to employ a worker with a disability, many additional barriers arise when the employer is passive in the recruitment process. Among these obstacles are attitudes and misconceptions in the workplace among managers, co-workers and in some cases worker representatives, a lack of knowledge about reasonable accommodations and incentives, and matching the capacities of the person to the skill requirements of the job. Underpinning the process of creating an inclusive workplace is ensuring that the company's ethos and culture are positive to disability. Disability awareness training (DAT) is one strategy in changing culture but this must be followed by addressing disability and employment at the level of a company's policies and procedures.

An important topic in DAT is to address the misconception that substantial costs are associated with hiring workers with disabilities. In fact, the costs of reasonable accommodations vary but most are low.[45] Furthermore, many jurisdictions provide substantial financial grants and supports for employers who wish to recruit a person with a disability and, in many systems, wage subsidies are available to compensate an employer for the reduced productivity of the employee if this is required.

[44] Foster, D. and Fosh, P., 'Negotiating "difference": Representing disabled employees in the British workplace', *British Journal of Industrial Relations*, Vol. 47, No. 3, 2009.

[45] Job Accommodation Network, US, **http://www.jan.wvu.edu/**.

Another misconception is that being in work may aggravate a person's existing health condition. It may well be that the opposite is the case. Being in work is actually associated with better health outcomes for people. It can be a rewarding and profitable option for both the employer and the worker once a proper risk analysis is carried out, the appropriate adjustments are made to the workplace and working conditions, and the worker's skills and capacities are effectively matched to the demands of the job.

The ILO has outlined the measures that employers and worker representatives can take to create an inclusive workplace in its Code of practice on managing disability in the workplace, which was approved at a tripartite meeting of experts in 2001.[46] While this is not targeted specifically at young jobseekers or young employees, it offers strong guidelines that could be adapted to the specific case of young people with health problems. The Code provides guidance on the respective roles of the employer, worker representatives and competent authorities. From a workplace perspective, the principal enablers of inclusion are an organisation's disability policy and strategy, company culture, processes and procedures, and knowledge and resources. Changing these requires gaining joint labour and management support for targeting young people with health problems as potential employees and valued colleagues.

Any approach must extend throughout the workplace and cover recruitment procedures, induction and staff training processes, career development, job retention and the reintegration of people who are absent as a result of ill-health regardless of cause. The human resources (HR) function must be at the core of any youth strategy, which must be integrated into a range of other company policies including occupational safety and health, workplace health promotion, equality and non-discrimination.

Employers can take many steps to increase the likelihood of young people with health problems having an equal chance of being recruited and/or maintaining employment. For example, employers can provide information in accessible formats and language, improve the accessibility of work premises, pay attention to signage and adopt a standard practice that workstations, tools and equipment, work schedules and performance requirements can be adapted or adjusted to the needs of the individual worker. They can also be proactive in their recruitment processes in order to encourage young people with disabilities to apply for work experience and employment, by advertising vacancies in multiple formats and by enabling young disabled candidates to compete on an equal basis with other candidates during the interview process. Thus, employers can play an important role in the inclusion of young people with health problems.

Economic factors

Finally, in the current economic climate, it is difficult to ignore the impact that wider economic factors can have on the likelihood that a young person with or without a health problem will obtain employment. Labour market conditions in terms of increasing unemployment levels, requirements for higher skills and qualifications in a knowledge-based economy, and a flexible labour market in which long job tenure is less common can all have an impact on career prospects. Nevertheless, even in difficult economic times, it is important to maintain a focus on active inclusion in the labour market.

In an equitable labour market, young people with health problems should not be disproportionately disadvantaged. In more favourable economic conditions, the participation rate of people with disabilities does not increase in line with the rates for the wider workforce. In the context of rising unemployment, their participation rates should not fall more rapidly, particularly with regard to young people with health problems. This balance can be achieved by ensuring that

[46] http://www.ilo.org/public/english/standards/relm/gb/docs/gb282/pdf/tmemdw-2.pdf.

young people are actively included in measures designed to encourage job creation and economic activity. Clearly, the emphasis that is being placed on economic growth and developing the productive capacity of the workforce has implications for young people with health problems. With increasing dependency ratios in society, it is essential that the talents and skills of all citizens capable of work are mobilised.

Active inclusion strategies in Member States

As discussed earlier, the majority of active strategies in relation to work and employment primarily focus on people who have already been in the labour market. These return to active life strategies are documented by Member States in the Mutual Information System on Social Protection (MISSOC).[47] Such strategies at national level can be characterised as being based on the two pillars of rehabilitation or retraining and preferential employment. Member States report a wide variety of active supports and services, including: medical, vocational and social rehabilitation, transitional benefits, occupational guidance, vocational education and training, access to aids and adaptations, personal assistance, subsidies for employers, wage support for workers, flexible pensions and benefits, and financial support to purchase services to maintain, restore and improve work capacity.[48]

In parallel, 13 Member States operate quota systems which vary in terms of the size of company to which they apply and the proportion of the workforce that should be people with disabilities. In some cases, this is accompanied by a sanction that an employer must pay if the quota is not reached.[49]

Regardless of the debate about the effectiveness of current active life strategies and the advisability of operating quota schemes, the key question here is how relevant these measures are to young people with health problems. One of the main barriers to accessing many of these services and supports is that they can be linked to eligibility for invalidity payments, which often requires a minimum period of affiliation in order to qualify. In other words, a certain period in employment is required to gain entry to the system. In some Member States, this is graduated according to age (for example, in the Czech Republic and Estonia) and in a few cases this minimum period is waived for people under a certain age (for instance, in Bulgaria and the Netherlands). The age limit varies from less than 20 years in Bulgaria to 16–18 years in Estonia. In other Member States, eligibility simply requires that the person is in employment at the time that the illness or injury occurs (for example, in Finland) or applies only to occupational injuries (for instance, in Luxembourg and Slovenia). The eligibility criteria can also mean a restriction to benefits from the quota in some Member States (for example, Italy). Whatever these requirements are intended to achieve, they are not particularly open when it comes to young people who are not at work and are experiencing health difficulties.

The Danish approach to flexicurity has often been presented as a model. In Denmark, the social partners are integrated into the decision-making process on the basis that they also have a responsibility to promote access for disabled people to the labour market. A change in the way that collective agreements are formulated has relaxed hire-and-fire rules but people who find themselves out of work receive quick retraining while drawing a high level of social security and they are soon back at work. However, reduced benefits are provided to young unemployed workers to increase the incentive to pursue education.

[47] MISSOC, *Developments in social protection in 2007*, synoptic report, Info 1/2008, available online at: **http://ec.europa.eu/employment_social/missoc/2008/01/2008_1_intro_en.pdf**.

[48] Summary of comparative tables of the EU27 using MISSOC.

[49] ibid.

In the case of people with disabilities, additional active labour market measures and assistance are provided to make it easier to find a job. The labour market approach is based on two elements:

- integration, which involves priority access to jobs, personal assistance, wage subsidies, remedial action, work instruments and mentoring;
- retention, which includes personal assistance, remedial action, work instruments and the upgrading of qualifications through courses, education and a job plan.

It may well be that this approach works not only because of the effectiveness of the measures being implemented but also because the wider Danish system has a tradition of broad welfare provisions and strong social security, active labour and educational policies and a long tradition of social dialogue.

If active strategies for people with disabilities do not fit well with the circumstances of young people with health problems, perhaps the measures implemented to include young people in general in the labour market can provide a better opportunity for this group. It is to be expected – given that two of the founding principles of the EU Disability Strategy are mainstreaming and non-discrimination – that such services should be open and useful to young people with disabilities in transition from school to work.

Additional and complex factors impact on people with disabilities above and beyond the labour market forces operating against the employment of young people in general. Many of the components of the systems operating in Member States focus on the maintenance of a basic standard of living. However, these can serve to lock young people with disabilities into dependency at an early age. Many systems have inherently low expectations of what young people can achieve and this is matched with the fact that many people have low or no formal qualifications on leaving compulsory education and, being new to the labour market, have no previous work experience. There is clearly a need to review current mainstream and specialised systems to support the transition to work for young people with health problems and to identify cases of innovation and good practice to break the cycle of unemployment and exclusion.[50]

A number of local active inclusion initiatives, many of relatively small scale, which specifically included young people with disabilities among their target groups were identified by a Eurofound review of innovation in employment guidance services of people with disabilities.[51] The approaches adopted by some of these initiatives provide an insight into the types of active mechanisms and measures that should be deployed more broadly throughout the Member States.

The Salva Vita Foundation in Hungary has been operating since 1996. It involves a school module to promote integrated employment for young people with intellectual disabilities. The aim is to prepare senior students for leaving school and taking up employment. The scheme has proved to be effective in supporting independent living for people with intellectual disabilities. It develops socialisation skills, prepares students for employment through skills development and prepares them for adult life and independent living. At the core of the initiative is a work experience programme for participants, delivered in cooperation with local employers. About 70% of the participants are aged 20–30 years.

[50] National Disability Authority, Dublin, 2006, **http://www.nda.ie/cntmgmtnew.nsf/0/A85B41AE9B9BD322802572BA00508B19/$File/stratexec.htm**.

[51] Wynne, R., McAnaney, D., O'Kelly, C. and Fleming, P. (Eurofound), *Employment guidance services for people with disabilities*, Dublin, Eurofound, 2006, case studies available online at: **http://www.eurofound.europa.eu/areas/socialcohesion/egs/search.php**. See also footnote 2.

In Slovenia, the training of job mentors aims to equip employment professionals with the necessary training to provide better support to specific target groups experiencing difficulty in accessing the labour market. The training programme includes knowledge of communications, motivational activities and the provision of advice to unemployed people and those with disabilities. An international exchange of the programme participants helped to solve common problems arising in practice. Some of the job mentors were aged 20–30 years.

The Competence Pool initiative in Sweden responds both to the needs of local industry for workers and the needs of unemployed young people with disabilities – many of whom had low qualification levels – to find a job. It is an inclusive mainstream service that provides flexible options, including disability-specific supports. The services provided include individual career planning, job preparation, job matching and placement, post-placement support and job coaching, and guidance for employers. It is effectively an SE model. The initiative caters for 25 people a year, all of whom are aged 20–30 years.

Vocational rehabilitation in cooperation targets a wide range of unemployed people in Sweden, including sick-listed unemployed individuals, unemployed persons on disability benefit, young people on job activation support, employed persons on sick leave who cannot return to their previous employment and people who are no longer entitled to a health insurance allowance. Some 66% of the participants have a registered disability. The project operates a coordination group at national level with representatives from two authorities – the National Labour Market Board (*Arbetsmarknadsstyrelsen*, AMS) and the Social Insurance Office (*Försäkringskassan*) – and corresponding groups at regional level. At local level, a working group involving the local social insurance office recruits the candidates after conducting a rehabilitation assessment. The multidisciplinary team comprises job placement officers, social insurance office coordinators and often an occupational psychologist and an occupational therapist.

The Spektra project in Sweden incorporates physical exercise and preventive healthcare to improve participants' physical and mental capacities to cope with a job. They are helped to prepare an individual plan which contains both short-term and long-term aims. The portfolio method is used throughout the programme to encourage the clients to reflect on their own development. A job practice officer concurrently plans opportunities for work experience. The participants are provided with a job practice period lasting up to eight weeks which is individually adapted to the person's needs. A job coach visits the participants to give support and to discuss possible adaptations or the efforts needed to raise competence. Half of the beneficiaries were aged 21–30 years.

The Eminus project in the Netherlands caters for young people with disabilities who find it difficult to take up vocational training as a result of mobility problems, fatigue or care requirements. The project provides distance learning in cooperation with five large companies. All jobs offered can be carried out by teleworking. The studies provided relate to positions such as remote network engineer, call centre employee, online secretary, online book-keeper, telemarketer and web designer. The initiative caters for 24 clients a year. Over 80% of participants were aged 20–30 years.

In Germany, the Füngeling Router job creation project provides job creation measures and successful job–worker matching initiatives for young people with disabilities, aimed at integration into employment. Other elements of the service include in-company prevention of disabilities affecting the workability of employees, integration management for employees with job relevant health restrictions and enabling disabled workers to keep their jobs through the provision of equal access to further training. The project also offers services to support overall career advancement and accompanies workers during the initial employment phase; in other words, it provides SE.

The Cooperative training and access to employment project in Germany aims to address the fragmentation of the services and resources between schools, youth administration, disability integration and support services, vocational training facilities, the Federal Employment Agency (*Bundesanstalt für Arbeit*, BA), employers and families. It attempts to optimise support measures into one comprehensive package. The range of services offered to people with intellectual

disabilities includes general career guidance, work placements, vocational training, support in finding a suitable job, assistance in making job applications, financial support and advice, confidence-building measures and raising awareness of the issues associated with disability.

Through the New Way training programme, the Slovenian Institute for Rehabilitation (*Inštitut Republike Slovenije za rehabilitacijo*) provides services such as vocational training, psychosocial rehabilitation and SE for people with disabilities. The target group of the initiative comprises young first-time jobseekers, long-term unemployed people, individuals who have recently become disabled and persons with brain injury or illness. The vocational rehabilitation period lasts from one to 24 months and aims to enhance the long-term employment possibilities of clients, either in the open labour market, in the social economy, in supported or protected employment, or in terms of social inclusion. About 48% of the group were aged 20–30 years.

Summary and conclusions

According to the latest figures, EU governments have been spending twice as much on illness and disability benefits as on unemployment benefits. Despite various schemes aiming to reduce work incapacity rates, some Member States have reported an increase in the inflow rates to disability benefits among young people – many of whom have mental health problems.

In some Member States, young people are the fastest growing age group of disability benefit recipients. The challenge to integrate young people with health problems into employment is likely to become more difficult in the currently unfavourable economic climate.

In effect, young people with health problems face a dual disadvantage. Firstly, because they are young, they face the same challenges as their non-disabled peers leaving compulsory education and seeking access to the labour market. Secondly, they must overcome the personal, health and environmental challenges associated with having a health problem or disability.

Active inclusion is an important strategy in combating the labour market exclusion of young people with disabilities; however, current policies and approaches tend to focus either on youth unemployment or on promoting the employment of people with disabilities. It is as difficult to find references to disability in the European Youth Pact as it is to find references to young people in the European Disability Strategy.

Nevertheless, the personal, social and economic costs of not intervening are unsustainable. For the individual, it can result in a lifetime of poverty, economic inactivity and social exclusion. Equally, people who enter the benefit systems at an early age represent a significant cost to society in terms of lost productivity and the increased burden on social protection systems. This can hamper governments needing to invest in job creation and foster trade by diverting resources into transfer payments; ultimately, it can result in an increasing social security and tax burden for employers and workers alike and raise the costs of employment.

Need for a revised and targeted strategy

A new approach is required to respond to the needs of young people with disabilities or health problems leaving full-time education. Instead of viewing them as vulnerable people in need of continuing care and focusing on their limitations in functioning, the focus should be changed towards the possibilities for them to function as adults in society and as productive members of the labour market. The goal of active inclusion policies is that people with disabilities are not excluded from society but are encouraged and empowered to participate as fully as possible in economic and social life, and in particular to engage in gainful employment.

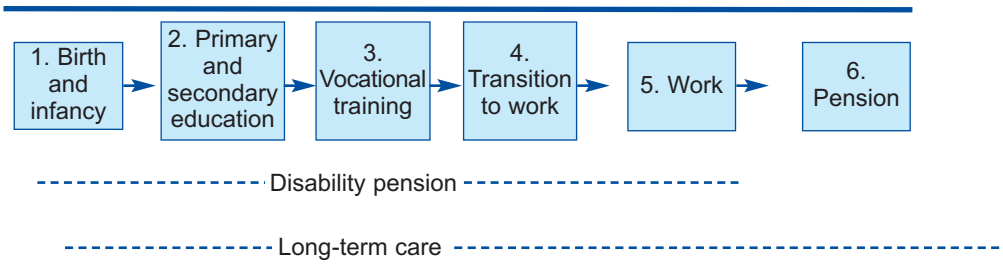
Of course, income security, good care and treatment are absolutely necessary for those who need them. However, social and economic integration must be an essential element of the response of employment and social protection systems. Regular work, work in sheltered environments, social and day activities can all play a role in this. Access to high-quality vocational education and training, customised employment guidance and counselling and incentives for both employers and young jobseekers are crucial.

Participation in work has many positive effects for society and the individual. It is a good use of human capital and has many consequences for the individual, including higher self-esteem, less dependency, better health outcomes, longer life expectancy and more satisfying social relationships.

For the agencies involved in labour market policy, employment services and social protection, this requires an important change of perspective. Instead of looking at what people cannot do – which is often a consequence of assessing people on the basis of eligibility for disability pensions – they need to focus on what people can do, and create ways to make these possibilities available. In many cases, this includes changing the attitudes of social partners regarding young workers with disabilities, removing barriers in public life and infrastructure, and creating adapted conditions in workplaces. It also carries implications for services and agencies to cooperate in terms of ensuring a smooth handover between systems, for example from school to the labour market. In addition, these agencies must work together in relation to dealing with young people with disabilities of working age.

Employment is a life stage in the progression to adulthood. After leaving the educational system, one of the biggest steps concerns entry into employment. Change is never easy and switching from one systemic approach to another often raises resistance from those working within the existing systems. As a result, these are important targets for attitude change and the updating of skills. Policymakers developing new and innovative elements and systems must acknowledge that it is not sufficient to change the way in which social security systems operate but that it is also important to take into account the prior life stages of the young jobseeker with health problems and to address the social, educational and psychological barriers that can result from participation in earlier systems. Moreover, they should recognise that the services and supports available to people in one system need to move with them into the next stage of development; this requires continuity in provision and effective communication between education and employment services (Figure 3).

Figure 3: *Legal conditions, including social security*



Transition to work is easier to achieve when it is well connected to the steps taken before. A problem is that during all stages different actors are involved, which leads to a breakdown in service provision and communication and a consequent loss of opportunities.

Good practice initiatives

Of course, there are also instances of more promising approaches to the employment of people with disabilities. The employment guidance services study (Wynne et al, 2006) provides many examples of initiatives which have relatively successful records in relation to the employment of young people with disabilities. In all, almost 60 case studies were undertaken in this project, with the results being collated in a Eurofound database (see previous chapter). The main

conclusions that can be drawn from this work are that employment guidance services that use proactive approaches, offer SE opportunities, adopt a case management approach and provide active and ongoing supports to employers have a better record of success.

A model for good practice in active inclusion should involve the following elements:

- a move must be made from recipient status on the part of the young person with a health problem to participant status;
- the strategic approach must be transformed from passive maintenance to active support;
- the criteria for actions must be independence rather than dependence;
- assessment must change from a labelling process of eligibility for pension to the identification of work skills and strengths;
- the system must remove disincentives and introduce incentives to seek employment and opportunities for voluntary work;
- sufficient employment supports and opportunity to develop skills and experience must be made accessible and available;
- there must be a move away from inflexible and restricted benefits and services to flexible and portable benefits and services;
- a multi-agency insular approach to services and support must be replaced by integrated, coordinated responses which are continuous over time and particularly at points of transition in the young person's lifespan.

The OECD report on transforming disability into ability (2003) proposed a number of policy changes to improve the labour market chances of people with disabilities, which should be taken into account.[52] These policy changes include:

- fostering a culture in which the person with a disability is encouraged to cooperate with rehabilitation measures;
- clarifying the distinction between ability to work and the right to income supports;
- the provision of individual work and benefit packages to people with disabilities;
- early intervention;
- involving employers in the job retention and recruitment processes;
- removing disincentives to work;
- reforming social protection and employment services;
- allowing people with disabilities to transfer from income benefits based on economic inactivity to jobseeking supports without loss of personal income.

[52] http://www.oecd.org/document/14/0,3343,en_2649_34747_35290126_1_1_1_1,00.html.

Furthermore, the European Commission Communication on the *Situation of disabled people in the European Union: the European Action Plan 2008–2009* recommends a range of interventions alongside active inclusion that can be developed to address the unique circumstances of young people with health problems in the labour market.[53] These include:

- flexible employment schemes;
- SE;
- positive measures complementing the existing European legislation on non-discrimination, such as models of good practices for the reasonable accommodation of disabled people in the workplace;
- flexicurity – that is, opportunities for disabled persons under the general framework of enhanced labour market flexibility combined with security to obtain and maintain their employment, by means of:
  - flexible and reliable contractual arrangements
  - part-time and temporary work
  - active labour market policies
  - comprehensive lifelong learning strategies
  - modern social protection systems providing adequate income support during periods of unemployment
  - job retention schemes preventing early exit from the labour market
  - a reform of financial compensation providing income replacement (disability benefits).

Thus, the major challenge is not a lack of ideas or strategies but a lack of insight into the complex and multi-dimensional challenges faced by young people with health problems in getting and keeping a job. Clearly, further research is required into the causes of increased benefits dependency among young people and the barriers to economic and social participation that they face. It is important to establish the extent of the problem and to identify examples of good practice in overcoming the challenges; the situation of young disabled people should be systematically and accurately documented.

Moreover, the extent to which mental health problems are implicated in the increasing number of younger people claiming disability benefits needs to be documented and understood. The compound problems associated with finding employment for younger people with disabilities are magnified when the cause of the disability has a mental health component.

This report has outlined the difficulties involved in such an endeavour, including the lack of comparative data, the diversity of characterisations of the target group and the lack of coordinated focus on the part of the responsible authorities at policy level. Nevertheless, the findings show that there is sufficient consensus that a problem exists and that there is a strong case for action.

[53] **http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2007:0738:FIN:EN:HTML**.

Annex: Country groups and codes

Country groups

EU15 15 EU Member States prior to enlargement in 2004 (Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom)

NMS 12 New Member States, 10 of which joined the EU in 2004 – sometimes referred to as the NMS10 (Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia and Slovenia) – and the remaining two in 2007 (Bulgaria and Romania)

EU25 EU15 and NMS10

EU27 27 EU Member States

Country codes

Country code	Country name	Country code	Country name	Country code	Country name
AT	Austria	**ES**	Spain	**MT**	Malta
BE	Belgium	**FI**	Finland	**NL**	Netherlands
BG	Bulgaria	**FR**	France	**PL**	Poland
CY	Cyprus	**HU**	Hungary	**PT**	Portugal
CZ	Czech Republic	**IE**	Ireland	**RO**	Romania
DE	Germany	**IT**	Italy	**SE**	Sweden
DK	Denmark	**LT**	Lithuania	**SI**	Slovenia
EE	Estonia	**LU**	Luxembourg	**SK**	Slovakia
EL	Greece	**LV**	Latvia	**UK**	United Kingdom

Richard Wynne and **Donal McAnaney**, Work Research Centre

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