

MENTAL HEALTH AMONG YOUTH IN ICELAND

WHO IS RESPONSIBLE? WHAT IS BEING DONE?



norden

Nordic Centre for
Welfare and Social Issues



AUTHOR: Jóhanna Rósa Arnardóttir (PhD)
CEO at Analysa

FOREWORD

Youth in the Nordic Region - Mental Health, Work and Education

All children and young people are a huge resource. We have never had such well-educated and competent youngsters in the Nordic countries as we do today. At the same time there are all the more young persons who claim to be suffering from mental illness, and young persons who, for various reasons, risk ending up in vulnerable situations. Growing mental illness amongst young people is one of the most serious public health challenges facing our Nordic society.

The project Youth in the Nordic Region focuses on young persons who suffer from or are at risk of suffering from mental illness, as well as their situation at school and their later transition to work and providing for themselves. A further important topic of the project is early retirement and retirement on mental health grounds amongst young adults.

As part of the project we have produced reports which shed light on various aspects of these areas. The report you are holding in front of you aims to give a quick, clear overview of who does what in Iceland in matters concerning young persons who suffer from or risk suffering from mental illness, and end up in long-term unemployment and with no meaningful purpose in life.

We have produced summaries of all the Nordic countries plus Greenland, the Faroe Islands and Åland. All summaries can be ordered or downloaded from www.nordicwelfare.org. We would like to point out to our readers that the summaries do not include everything that is done and that important and useful contributions may be lacking.

The Nordic countries have a lot of challenges in common; one of these is to ensure that all children and young persons enjoy good living conditions. We also know that particular efforts and investments are required for a heterogenous group of young people who are at risk of exclusion owing to mental illness, dropping out of their studies, long-term unemployment and other factors.

We can learn a lot from each other's different solutions and contributions. So let yourself be inspired!



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THE MENTAL HEALTH PROBLEMS OF YOUNG PEOPLE IN ICELAND

The prevalence of mental disorders among Icelandic people aged 20-59 has been estimated at 22% (Ministry of Health and Social Security, 2004). However, little information is available about the prevalence of mental health problems among young people aged 16-29.

Need for mental healthcare services

Research on the mental health of young people aged 18-24, and social exclusion among unemployed youths in Scandinavia in 2000, showed that economic deprivation is associated with mental health problems but was not linked to unemployment (Hammer, 2000). This study showed more mental health problems among young people in Iceland than in Denmark, Finland, Norway and Sweden.

In a survey (*Í. Heilsa og líðan Íslendinga*) conducted by the Directorate of Health in 2012 among people aged 18-84 in Iceland, participants were asked if they suffered, or had suffered, from long-term depression. Thirteen per cent reported that they had. A gender difference could be seen, with 16% of female reporting that they had suffered compared to 10% of men (Guðlaugsson, Magnússon & Jónsson, 2012).

One survey has examined self-perceived physical and mental health among upper secondary school students aged 16-19 in Iceland and the other Nordic countries (ICSRA, 2010). The results show that 74% of Icelandic youths believe their mental health is good. When broken down by gender, 79% of males reported good mental health compared to 69% of women. However, the percentage of youths who believe their mental health is good is lower in Iceland than in most of the Nordic countries; the lowest percentage was in the Åland Islands (71%) and the highest in Finland (79%).

When asked how often they had experienced a range of physical and mental discomforts over the last six months, more than 60 per cent of the respondents reported

seldom or never having experienced dizziness, sadness, loss of appetite or stomach aches. Tension, stomach aches, headaches, and difficulty sleeping or concentrating were more likely to be experienced sometimes or often, although only a small proportion, less than 5 per cent of respondents on each item, reported always experiencing physical and mental discomfort.

The European Social Survey (ESS) is a multi-country survey covering 29 countries. The European Social Survey in 2012 shows that 86% of participants (85% of males and 88% of females) in Iceland aged 16-29 perceived their general health as good. About 17% (19% of males and 15% of females) believed that illness, disability, infirmity or mental health problems hampered their daily activities. Forty-seven per cent (30% of males and 51% of females) had felt depressed at least some of the time in the previous week. About 52% (a higher percentage of females than males) felt anxious at least some of the time in the previous week. When Iceland is compared to Denmark, Finland, Norway and Sweden, a higher percentage of young people reported they had felt depression or anxiety in the previous week in Iceland (see appendix II).

Research has also shown that there are gender differences in psychological distress (Bjarnason & Sigurdardottir, 2003). However, depression is more likely to be predictive of suicidal behaviour among males than females (Bjarnason, 1994; Norðfjörð, 2001). Boys are at greater risk of suicidal behaviour and are more often treated for drug use in the mental health services, while girls are more likely to suffer and receive health-care treatment generally. As has been shown here, self-perceived mental health is worse among girls than boys.

The Social Insurance Administration

The social security pension system in Iceland is primarily tax-funded and provides universal coverage, with rights based on the period of residence in the country. There are flat-rate benefits with a high degree of income testing (Ólafsson, 2011b). The social security pension has three components: the basic pension, a pension supplement, and a household supplement. In 2012, 7.5% of the population between the ages of 18 and 66

were disability pensioners; among 18-19-year-olds the proportion was 1.9%, among 20-24-year-olds 2.4%, and among 25-29-year-olds 3.4%. There are higher percentages of male than female disability pensioners in the 18-24 age group, but from the age of 25 onwards the percentage of females is higher (Statistics Iceland, n.d.).

Disability pensions are most often received as a result of mental and behavioural disorders: they comprised 38% of all disability pensioners in 2013. Among those younger than 30, 70% of male pensioners and 57% of female pensioners received their pension as a result of mental and behavioural disorders. The Social Insurance Administration (*L. Tryggingastofnun ríkisins*) has the authority to negotiate with employers in the labour market to hire staff that receive an invalidity or rehabilitation pension. The institution contributes a portion of salary costs. The number of such agreements has risen from 358 in 2010 to 656 in 2013 (Tryggingastofnun ríkisins, 2013a).

Research has shown that disability pensioners face great problems due to exclusion from the labour market and prejudice, and there is an urgent need to honour their fundamental human rights to engage in social activities, have work, be in connection with others and be full participants in society (Thorlacius & Olafsson, 2010; Jokumsen & Traustadóttir, 2014). A survey among disability pensioners in 2009 showed that 56% of mentally ill pensioners encountered prejudice and 79% some or great social isolation; only 27% had been employed in the previous six months and 20% participated in work rehabilitation (Hannesdóttir, 2010). Specific figures were not available for the group of young people, aged 16-29 who were mentally ill. Research has also shown that prejudice and negative attitudes toward individuals experiencing mental illness is greater if they define the condition as an illness (Ólafsdóttir & Bernburg, 2010).

Suicides

Mental health illnesses are serious disorders that can lead to death and can provoke suicidal behaviour. Statistics Iceland has published the number of deaths by suicide among 16-29-year-olds, by gender, between 1981 and 2009.

The Icelandic National Health plan passed by the Althing in May 2001 provided for seven priority projects, one of which concerned mental health. In this area, two targets were set: to reduce the prevalence of suicides by 25% and to reduce prevalence of mental disorders by 10% (Ministry of Health and Social Security, 2004). The statistics show that there are 5-10 suicides among this age group every year and that there were more than 15 in 1990 and 20 in 2000. In total there were 33 suicides on average a year in this period (1981 to 2009), with the lowest number in 1981 and highest number in 2000 (Source: Statistics Iceland, n.d.). Of the Nordic countries, only Finland had a higher suicide rate (see table 10 in appendix III).

In the decade between the years 2003 to 2013, an average of 102 individuals (more females than males) were hospitalised each year because of self-harm (Embætti landlæknis, 2014b). Among those in the 18-27 age group who were hospitalised in the mental health services of Landspítali (and Kleppur), suicide attempts were the main reason for admission and more males were involved than females. Interestingly, males were more likely than females to have been arrested by the police in the months before the suicide attempt (Bárudóttir et al., 2014). The relationship between ADHD and mental disorder is well known. It is believed that about 6% of children have ADHD in Iceland, and of them, about 70% will continue to have symptoms into adulthood (Sigurbergsson, 2008).

The Red Cross (2014) conducted a study into which groups in Iceland are vulnerable and/or marginalised. Results showed that those who are in the most difficult situation are disabled people, elderly people of limited means, single and low-income parents, long-term unemployed people, young people, uneducated young males, immigrants, and the children of immigrants. About 9-10% of the population in Iceland earn salaries below the specified minimum-wage threshold and are therefore in danger of experiencing poverty. According to the Red Cross (2014) there is need to address prejudices, formulate immigration policies, activate the inactive group and more collaboration between the welfare system, academia, municipalities and NGOs to break the vicious circle and to work against poverty.

Mental health problems in school-aged children

Based on research in 2005, about 19% of children in compulsory schools in Iceland suffer from serious health problems. This figure includes 7% with of mental health problems, i.e. 6% with ADHD, 1% with anxiety, and 1% with depression; a higher percentage of boys than girls have these problems. There was more depression among 13-15-year-olds than younger cohorts. About 78% of health professionals (doctors and nurses) believed that children with mental or behavioural problems needed better services than they were receiving (Miðstöð heilsuverndar barna, 2005).

Only compulsory school is mandatory. In upper secondary schools most students are 16-20-year-olds and after completion higher education can be begun at university. In 2013, about 95% of 16-year-olds attended upper secondary school but only 69% of 19-year-olds remained in school (Statistics Iceland, n.d.). When compared to Sweden, Finland, Denmark and Norway, a lower percentage of Icelanders complete upper secondary education (OECD, 2011). About 28% of dropouts in spring 2014 were due to school exclusion (breaking school rules, such as not attending classes as required), 11% due to employment and 9% due to mental illness (Mennta- og menningarráðuneytið, 2014). The dropout rate in autumn 2013 was similar, but the figure for mental illness had increased to 12%. Mental illness may be contributing factor in cases of school exclusion.

According to a recent study of young people with mental illness in Iceland, the Faroe Islands and Norway (the Nordic Centre for Social and Welfare Issues, 2016) young people with mental health issues in these countries are often not identified until late in their school career. It takes time before they receive targeted and effective treatment, and the transition back from illness and absence to school is not optimal.

Young prisoners

About 43% of prisoners (162 out of 373) in Iceland in 2013 were aged 30 or younger (Fangelsismálastofnun, 2013). Research shows that half of female prisoners experience depression and anxiety, while the figure for male prisoners is 26% (Sæmundsdóttir, 2005). Research among 90 male prisoners in Iceland shows that 50% of them met criteria for ADHD in childhood and, of those, 60% were either fully symptomatic or in partial remission of their symptoms and had serious co-morbid problems, primarily associated with antisocial personality disorder and substance dependence. Attention deficit hyperactivity disorder (ADHD) is associated with a number of psychiatric conditions, mostly personality disorder, substance misuse, anxiety and depression (Einarsson et al., 2009). Research has shown that about one-third of prisoners are studying, which will help them later, but many of them will face prejudice and have difficulty in finding jobs after they have completed their sentences (Ragnarsson & Gunnlaugsson, 2007).

Use of Antidepressants

Studies have shown that consumption of antidepressants is higher in Iceland than in other Nordic countries (Althingi, 2014; Jóhannsson et al., 2014; NOMESCO, 2013; OECD, 2013; Vilhelmsson, 2013). Expenditure by Icelandic Health Insurance on antidepressant medicines is higher than for other medicines, and was ISK 3400 million in 2012 (Althingi, 2014). According to OECD (2013). The consumption of anti-depressants has also increased significantly in most OECD countries since 2000. Guidelines for the pharmaceutical treatments of depression vary between countries, and there is also a great variation in prescribing behaviours among general practitioners and psychiatrists in each country. Iceland reported the highest level of consumption of antidepressants in 2011, followed by Australia, Canada, Denmark and Sweden.” (OECD, 2013).



THE OVERALL RESPONSIBILITY AND NATIONAL GUIDELINES

The Ministry of Welfare, established in 2011 through the merger of the Ministry of Health and the Ministry of Social Affairs, is responsible for administration and policy with regard to social affairs, statutory health and social security in Iceland. Mental health issues, therefore, are now the responsibility of a single ministry instead of the former two.

Until recently there were no national policy for mental health in Iceland. The current national health plan, which extends until 2020, contains specific objectives and measures regarding mental health and preparations for a comprehensive mental health policy, together with an action plan. The previous national health plan, which ran until 2010, set two targets specific to mental health: to reduce the number of suicides and to reduce the prevalence of mental disorders in the general population by 10% (Ministry of Health and Social Security, 2004). In addition, one of the social objectives of Iceland 2020 – a governmental policy statement for the economy and the community is to improve well-being and mental health so that the average measurement on the WHO 5 Well-being Index would rise from 64 in 2009 to 72 in 2020 (Ólafsson, 2011a). However, in November 2015 proposal for mental health policy and action plan for four years were submitted to the Parliament and it was accepted 29th of April 2016 (Althingi, 2016).

The national policy for mental health in Iceland is to improve well-being, better mental health and more active community participation of people with mental disorders. Emphasis will for example be put on integrated and continuous services to people with mental disorders, the upbringing of children and to promote their well-being and to avoid discrimination on the basis of mental health. To approach these goals there is an action plan. The municipalities and state will for example submit an agreement on how they intend to conduct joint services to people with cognitive problems in the relevant

service areas. It is proposed to offer more psychological services in the health care centres, the establishment of mental health teams, BUGL (Child and Adolescent Psychiatric Department at Landspítali) will be strengthened further, the knowledge within the social and health services to deal with less severe problems will be increased and more support for children of parents with mental health problems. More part-time jobs will be offered for those with mental health disorder who are inactive. There will be actions to screen for anxiety and depression in schools and work on mental health promotion in schools. Reduce and prevent suicide among young people. The focus is on actions to reduce stigma, including drawing up guidelines for considering issues relating to people with mental health problems (Althingi, 2016). There are no policy or actions focused only on those who are 16-29-year-olds although many of these proposal will possibly help them.

The healthcare system

The Icelandic healthcare system (*I. geðheilbrigðisþjónustan*) is mainly state funded, administered and supervised. Primary healthcare centres and hospitals are state run and healthcare personnel are employed by the state, with the Directorate of Health playing the main supervisory role. A private sector runs parallel to the public sector but it is largely funded by the state. The main aspects of the private practice are specialist services, some healthcare centres, psychiatrists, occupational therapists, and psychologists.

There are about 80 primary healthcare centres (*I. heilsugæslustöðvar*) located around the country, staffed by 233 general practitioners (Doctors' Registry 24.10.2014). In 2009 600,000 visits were made to primary healthcare centres each year (Directorate of Health, n.d.). The primary healthcare entity of the capital region operates fifteen health clinics and four additional specialised centres. The primary healthcare centres offer various medical and nursing services, infant and maternity services, school healthcare, etc. The activities of the health clinics are directed towards neighbourhood services and are expected to serve inhabitants of particular parts of the capital region. Current procedures assume that the primary healthcare centre should be the first point of contact in the system for patients, but there are no general penalties for directly seeking services of self-employed specialists (Ólafsson, 2011b).



Beyond the primary healthcare system, there is one major, high-tech university hospital, Landspítali (*I. Landspítali-háskólasjúkrahús*), that serves the whole country, as well as a teaching hospital in Akureyri (the largest municipality in the northern part of the country) and 13 smaller local hospitals, some operated partly as nursing homes for the elderly (Ólafsson, 2011b).

Mental health services in the primary healthcare centres

The primary healthcare centre of the capital region offers services for individuals with mental health disorders and their families (*Geðheilsa-Eftirfylgd*), where a team of professionals assists through interviews, family therapy, group therapy, home visits and other types of support. About 7.6% of visits to primary healthcare centres in the country are in connection with mental illnesses (Directorate of Health, n.d.). Yet according to Sveinsdóttir (2014), access to psychologists is only available in ten of the 15 clinics in the capital region, and only five clinics have psychologists in full-time positions. There is an urgent need for more to meet the demand.

Primary healthcare centres in the capital region also work in cooperation with an association of professionals and individuals dealing with mental health problems. These services are based on the ideology of empowerment and personal assistance in community existence (PACE)¹. A quality evaluation survey was conducted in the summer of 2012 among those who had participated in this programme. Among those who responded to the survey, 30% were employed and 10% were in education. About half of them were still participating in the programme, and some were also receiving therapy in the mental health services of Landspítali and from private psychologists and private associations such as Hugarafl and Al Anon. The results showed that 84% were satisfied with the services they had received and about 45% were using less medication after receiving these services; 87% said they would recommend the services (Tryggvadóttir, 2012). The response rate in the survey was low, so caution should be exercised in interpreting these results.

¹ See www.power2u.org

Mental health services in hospitals

Key figures about the mental health system in Iceland obtained from the World Health Organisation website (see appendix III), show that in 2011 there were 2.13 outpatient facilities for mental health per 100,000 of the population and 42.82 beds per 100,000 for mental health patients in general hospitals. Government expenditure on mental health, as a percentage of total expenditure on health, is 8.69%. There are fewer beds for the mentally ill in general hospitals in Iceland than in Denmark and Finland.

In 2013, 2,420 people were discharged from the mental health services in Iceland, the majority from Landspítali (Directorate of Health, n.d.). About 2000 patients (50% males and 50% females) have been hospitalised in the mental health services of Landspítali annually in the past decade (Embætti landlæknis, 2014a). In 2013 there were 2,101 discharges (1,439 patients). Most of them needed general mental health treatment (65%), followed by drug abuse treatment (25%), rehabilitation (8%) and 2% received treatment in forensic psychiatry. Of these total discharges, 651 were aged 20-29. Most of them needed general mental health treatment or treatment for drug abuse (see appendix I table 1). This applied to both males and females. More males than females received treatment for drug abuse; the gender balance was reversed among those who received general treatment. Number of ambulatory (*I. göngudeildir*) visits were 25,319 in 2013 (Embætti landlæknis, 2014a). The largest hospital outside the capital regions is in Akureyri and the only one with special psychiatric unit, there were 73 admissions of patients with mental disorder age 20-29 (Sjúkrahúsið á Akureyri, 2014).

Rehabilitation is a large part of the mental health care system, offered by hospitals, health clinics and often in private practices. Sometimes patient attend outpatient services afterward, i.e. get medicine, meet doctor or therapist. Landspítali offer rehabilitation for patients afterwards, such as in Kleppur. The rehabilitation facility at the hospital only open for young people aged 18-30 (I. Endurhæfing LR Laugarásvegi 71) has the capacity for seven beds but some are treated on daily basis. Treatment in this facility takes 12-24 months, and the emphasis is on getting patients to be more active through physical activities and domestic work and the treatment is based on the pro-

gramme “Early Intervention in First Episode Psychosis” The rehabilitation programme is run in cooperation with the Directorate of Labour, VIRK (Vocational Rehabilitation Fund), a fitness centre and the upper secondary schools.

Patients suffering from anxiety, serious depression or psychosis can attend ‘Hvítabandið’, which offers treatment for young people twice a week in treatment programmes that last for about four months (Embætti landlæknis, 2014a). Reykjalundur (n.d.) is the largest rehabilitation centre in Iceland. About 130 mentally ill patients receive treatment there annually. Reykjalundur is an NGO and admission is based on referral from a physician.

According to NOMESCO (2013) there were 6.0 hospital treatments for 15-29-year-olds per 1000 in psychiatric units across the country. When broken down by gender, there were 6.2 for males and 5.7 for females.

According to the registry of doctors, 106 psychiatrists are licenced to work in Iceland (Directorate of Health, n.d.). In the mental health services at Landspítali in 2013 there were 53 physicians/doctors, most of them psychiatrists, employed in 48 full-time positions, 119 nurses in 92 full-time positions, 55 psychologists in 48 full-time positions, 45 social workers in 40 full-time positions, and 24 occupational therapists in 17 full-time positions (Geðsvið Landspítala, 2013). In Akureyri there are five psychiatrist positions, 2.8 full-time positions for psychologists, one social worker and 2.5 full-time positions for occupational therapists (Sjúkrahúsið á Akureyri, 2014).

Human resources in the mental healthcare system seem to be acceptable in comparison to other Nordic countries (see Appendix III). In 2011 there were 22.3 psychiatrists per 100,000 of the population and, of the OECD countries, only Switzerland had more psychiatrists (OECD, 2013).

At Landspítali is Child and Adolescent Psychiatric Department (BUGL), a division within Women’s and Children’s Services, and is for children up to 18 years old. BUGL work closely with the parties conducting the primary diagnoses, such as hospitals out-



side the capital, health care centres and social services (Landspítali, 2016). There are 17 beds but 6,501 ambulatory visits (*I. göngudeildir*) in 2014, waiting lists are long where 150 children were on the list in January 2015. The data is not grouped by age so there is no information about those age 16-18. There are needs for more doctors, nurses and other professionals at BUGL (Embætti landlæknis, 2015).

Social Services

In addition to the healthcare facilities to address mental health problems, there are 32 social services offices around the country. The 74 municipalities are responsible for these. Six of these offices are situated in the capital region, including one in Reykjavík, which operates six municipal service centres (Icelandic Association of Local Authorities). The aim of the municipal service centres in Reykjavík is, on the one hand, to provide information and advise people with health issues about social entitlements and, on the other, to provide support in cases of social or personal problems. The consultants at the service centres provide information about entitlements/services, consultation and support. They may also provide information about other service options, as well as directing people to the resources that are appropriate in each case (Reykjavík Municipality, n.d.). There are 173 social workers employed in the social services, 128 in the capital region and 45 outside the capital region. In six social service offices there are no fully qualified social workers. These figures do not include the number of those working with disabled individuals (Guðjónsdóttir, 2011). In 2012, 383 social workers were employed within the healthcare services (Statistics Iceland, n.d.).

WHAT IS BEING DONE

An expert conference was held in Reykjavik in October 2014, *Children's mental health and well-being: Policy and future directions in the Nordic countries* (Velferðaráðuneytið, 2014). The conference, arranged by the Ministry of Welfare and Directorate of Health, focused on mental health promotion and prevention. Among the experts who presented their findings at the conference, there was general agreement on the importance of focusing on children's mental health and well-being, with a need for further research and policies. Much of the burden of disease can be traced to mental illnesses, and half of them start by the time sufferers are in their mid-teens and 75% by their mid-20s.

The conference also emphasised that health promotion can improve mental health and affect resilience and knowledge about what is appropriate. More funding is needed in the sector, to help promote health, prevention, intervention and evidence-based knowledge. There needs to be more cooperation between specialists in the healthcare services and social services. Good primary healthcare centres are important to serve parents and their children, and they have a positive impact on general health and mental health among those children later in life.

High quality child care will increase well-being among children and decrease the effects of social inequality. The family and the schools should be at the forefront of preventive measures against mental health problems. However, there is still a need for common indicators of mental health illnesses in order to identify priorities, and information about how to measure the effectiveness of measures taken.

Mental health problems seem to be on the increase, but some measures have been effective, such as the preventive measures implemented in Denmark to reduce the number of suicides. There are many reviews available on what works and what does not, but

these do not necessarily focus on mental health problems, which remain in the shadow of other diseases. Patients with mental health problems face prejudice and stigma, and can find it difficult to obtain appropriate treatment (Velferðarráðuneytið, 2014).

Development of mental health policy

In November 2015 the minister of health introduced a resolution on a mental health policy and an action plan for four years (Althingi, 2015). The main aims of the policy is to improved well-being, better mental health and more active community participation of people with mental disorders, both in and outside the capital region. Emphasis will for example be put on integrated and continuous services to people with mental disorders, the upbringing of children and to promote their well-being and to avoid discrimination on the basis of mental health.

To approach these goals there is an action plan. When looking at these goals there are many factors that could help those aged 16-29 although no specific action is only focused on this group. The municipalities and state will submit an agreement on how they intend to conduct joint services to people with cognitive problems in the relevant service areas. It is proposed to offer more psychological services in the health care centres where 50% of the health care centres offer such services by the end of 2017 and 90% 2019. Establishment of mental health teams should be completed in all part of the country by the end of 2019. BUGL will be strengthen further and there will be no waiting lists by the end of 2019. The knowledge within the social and health services to deal with less severe problems will be increased and more support for children of parents with mental health problems. The goal is that 80% of the social and health care staff have attended courses related to this issue before 2020. All patients with mental disorder will have access to suitable residence when leaving the hospital by the end of 2016.

In the field of prevention, particularly towards children and with the intention of reducing mental health problems among children, it is proposed to implement a team to conduct the counseling and support of parents and families. The goal is that self-perceived mental health among those aged 13-15 will be rated as good among 90% of the children by the end of 2019 instead of 81.1% in 2014. There will be screening for anxiety

and depression in schools and work on mental health promotion in schools. Evidence based action plan to prevent and to reduce suicide among young people will be implemented by the end of 2017. The focus is on actions to reduce stigma, including drawing up guidelines for considering issues relating to people with mental health problems. Inactive people with mental health problems will be offered part-time jobs in public institutions. There will be more screening for mental health problems among refugees and increase interpreter services for those who are mentally ill (Althingi, 2016).

Cooperation between healthcare and social services

The cooperation between healthcare and social services comprises a team to find residential options appropriate for a person with a mental health disorder. Surveys are conducted among patients before they are discharged from the hospital. According to the Directorate of Health there needs to be more cooperation with the family of the patient, more opportunities for patients to meet social workers, psychologists, and physiotherapists, and more work on how to assist patients after they leave the hospital. Medication instructions, medicines and prescriptions need to be clear and compatible between the different professionals that treat each patient (Embætti landlæknis, 2014a).

Professionals from the healthcare and social services have organised teamwork in an attempt to find better solutions for patients. One such team is for people with mental health disorders living in their own households or with their parents. Many of them have been admitted to the mental health services and about 60-70 receive support. In 2013 there were two teams, one organised by mental health services at Landspítali (*I. geðsvið*) and the other organised by the social services (*I. velferðarsvið Reykjavíkurborgar*). These two service branches cooperate with each other and also with the municipal child protection services and social service centres (*I. þjónustumiðstöðvar*). Patients are helped to deal with everyday activities until they can cope by themselves and then they attend further treatment in the form of therapeutic interviews.

In Reykjavík municipality there are 13 communal residential homes (*I. samþýli*) for people with mental health disorders, and in the wider capital region there are six more run by NGOs (Jónsdóttir, 2013). In a survey of 215 people with mental health disor-

ders in need of residential homes (out of the 493 registered as being in need of such services), 33 (15%) were aged 18-25 and 33 (15%) were aged 26-34. Among the total sample (215) 68% wanted residential homes with professional services and only 21% preferred to live on their own (Félagsmálaráðuneytið, 2006). The results also show that the largest number of participants in the survey came from Landspítali mental health services (39%) or near the capital region, and only 20% from other regions of the country. The Red Cross is one of the voluntary organisations operating seven shelters for people with mental disorders, in Reykjavík, Hafnarfjörður, Akureyri, Akranes, Húsavík and Ísafjörður.

Government Agency for Child Protection

On behalf of the Ministry of Welfare, the Government Agency for Child Protection (*I. Barnaverndarstofa*) is responsible for everyday administration of child protection services. Examples are offering advice to Child Protection Committees at local level, monitoring the work of these committees by reviewing annual reports, supervising and monitoring institutions and homes operated or supported by the government for children and youth, and assisting Child Protection Committees in finding suitable foster parents (Barnaverndarstofa, n.d.).

The agency is also responsible for operating specialised services in child protection. There are two principal services in operation: a centre for investigating child sexual abuse cases and treatment facilities for children and young people. In 2013 the Child Committees handled 1,032 cases for children aged 15 to 19, 506 boys and 526 girls (Barnarverndarstofa, 2013 p. 116). Risk behaviour is the most common reason for a child being registered with the Government Agency for Child Protection, but among those who receive special treatment, neglect² is the main reason (Barnarverndarstofa, 2013 p.127).

2 Neglect is defined in terms of the SOF classification or a lack of the necessary action, which leads to harm, or is likely to result in harm, to the child, e.g. when the parent fails to provide the child with the necessary supervision, control or security, thereby putting his or her welfare at risk (Barnarverndarstofa, 2012).

Of those in the 16-18 age group who received special treatment, 30 were registered in Multisystemic Therapy (MST), 18 at the youth treatment clinic Stuðlar, 141 in a closed treatment clinic at Stuðlar and 17 in treatment homes. Stuðlar is a closed institution providing accommodation for juveniles placed in an emergency unit and a treatment unit by the decision of the child welfare committees. MST is a treatment that has been used since 2008; it has been tested and found to have beneficial impact on participants. Young people are treated in their own environment; professionals work in close connection with the family and the school and help the young person whenever needed, 24 hours a day.

A survey of participants who were treated by the Agency in 2000-2007 shows that half of them were later treated for mental health problems (42% of males and 66% of females), 41% of males and 18% of females were in prison, and only 23% received follow-up treatment (Barnaverndarstofa, 2013; Karlsdóttir, 2012). The Icelandic National Audit Office evaluated the Government Agency for Child Protection and one of their main conclusions were that there are two groups of children that are not getting good enough services from the Government Agency for Child Protection: Those age 16-18 with serious drug abuse problems or criminal behaviour; and those children with multifunctional problems, such as mental disorder and behavioural problems (Ríkisendurskoðun, 2015).

Upper secondary schools

The National Curriculum Guide for upper secondary schools lays down the framework and conditions for learning and teaching based on the principles of existing laws, regulations and international conventions. Six fundamental pillars (Literacy, Sustainability, Health and Welfare, Democracy, Equality, and Creativity) have been developed with this framework and form the essence of the educational policy. This focus on health and welfare will possibly help those with mental ill health problems and the inclusion of such a statement as one of the fundamental pillars of education is positive. There are, however, limited health-care services available at upper secondary schools, and availability has decreased in the capital region since 2011 (Government Bill on Healthcare Services in Upper Secondary Schools, þingskjal 100 144.löggjafarþing 2014-2015).

It is also important to bear in mind that, despite the high drop-out rate from upper secondary schools, about 38% of the 30-34 age group in the population have completed tertiary education, which is a good indication of the educational level of the nation as a whole (Arnardóttir, 2014).

In March 2015 the Directorate of Health published a handbook for upper secondary schools about mental health promotion, including detailed information on how to improve mental well-being in schools (Daníelsdóttir, 2015). This publication is part of the project “*Heilsuefandi framhaldsskóli*” and is based on the European project and cooperation named *European Network of Health Promoting Schools (ENHPS)*. Guidance counsellors stress the importance of screening for young people who are at risk of becoming dropouts and helping students in upper secondary schools to cope with the difficulties that they face in schools.

The social services

The social services offer some programmes in cooperation with other services such as AMS and Stigur, and with the Directorate of Labour, where recipients of financial assistance from the municipalities are helped to find employment or work rehabilitation (Icelandic Association of Local Authority, n.d.). According to Thorlacius and Olafsson (2010) it is important to find jobs for the disabled and strengthen the vocational rehabilitation system in Iceland and to support employment and social participation among this group.

The Icelandic mental health plan will look into two programmes, Improving Access to Psychological Therapies (IAPT), and the project *Breiðholtsmódel*. IAPT is the NHS programme³ offered in the UK and approved by the National Institute of Health and Clinical Excellence (NICE) for treating people with depression and anxiety disorder (Velferðarráðuneytið, 2014).

³ See <http://www.iapt.nhs.uk/iapt/>

Breiðholtsmódel has been developed since 2007 by a professional team at the social service centre in the Breiðholt district in Reykjavík, one of the centres operated by the social services in the capital. The model was implemented to solve the urgent needs of young people in this neighbourhood (which is recognised as dealing with more problems than most other districts in the capital region). The model is based on the ideology of phased and early treatment (*I. stigbundin og snemmtæk þjónusta*) where there is screening for the problems in order to detect them as early as possible and to offer suitable remedies, beginning with soft intervention, and based on clinical guidance. Screening starts in the final year of compulsory education, and comprises a survey where students answer a questionnaire on anxiety and depression symptoms. If their scores are above defined benchmarks, psychologists will contact parents and offer their services, interviews, counselling or participation in courses such as cognitive behaviour therapy (*I. HAM*). These courses last six weeks and are held regularly in all districts, and are offered in collaboration with the mental health services of Landspítali.

Cognitive behavioural therapy is a psychological treatment approach based on successful methods of enabling people to tackle difficult emotions and behavioural patterns. The aim is to help mentally ill people to cope with disorders, to reduce consumption of medication, and to offer treatment and services as quickly as possible.

Three institutions offer services for children with severe mental disorders: BUGL (Child and Adolescent Psychiatric Department at Landspítali), the State Diagnostic and Counselling Centre, and the Government Agency for Child Protection. The high-risk group in Iceland, i.e. those in need of special support that the child protection system and the social services had not adequately supported, was estimated to be about 8-12 individuals in September 2013 (Velferðarráðuneytið, 2013a). One way of dealing with this is to offer special support in accordance with the law on disability, where the goal is to offer long-term treatment and residential homes.



About 15 young people born in 1982-1994 were hospitalised at the mental health services in Landspítali and needed further treatment after they left the hospital; some of them have been hospitalised 80-90 times over a period of eight years. The illnesses of these individuals were already known when they were children. What they have in common is the need for residence solutions; they live in poverty and take part in various treatments within the system (Velferðarráðuneytið, 2013a). In 2013 there were 650 individuals aged 18-29 with disabilities under treatment by the social services, 65 of them due to mental or behavioural disorders (Velferðarráðuneytið, 2013b). Consequently, the number of young people in the high-risk group is possibly much higher than 8-12.

VIRK - The Vocational Rehabilitation Fund

The Vocational Rehabilitation Fund VIRK (*I. VIRK starfsendurhæfing*) offers services for individuals who are unable to work due to barriers caused by health problems and who have referrals from physicians. They must be willing and able to perform routine daily activities and be active participants in vocational rehabilitation. This is a private foundation, of which all the major unions and employers in the labour market in Iceland are members. VIRK also works in cooperation with the healthcare services (*I. geðsvið Landspítali*), the Directorate of Labour and the social services (VIRK, 2014).

In 2013, 1,590 individuals participated in VIRK, 21% or 327 were younger than 30. Of this group 63% were females and 37% were males. Among those who received these services, 37% did so because of mental illnesses. Among all the individuals that have completed VIRK, 49% were receiving salary from employment.

The Directorate of Labour

The Minister of Social Affairs is responsible for the Directorate of Labour (*I. Vinnumálastofnun*) and manages the employment service within the country, as well as the day-to-day administration of the Unemployment Benefit Fund, the Wage Guarantee Fund, the Maternity/Paternity Leave Fund, and payments to parents of children with long-term illnesses. There are nine offices, eight of them outside the capital region. There has been increasing emphasis on labour market activation and inclusion meas-

ures since the economic crisis in 2008. Before the crisis, Iceland did not have a large array of measures to activate individuals, since the employment rate was generally very high and unemployment rate low and short-term (Ólafsson & Arnardóttir, 2008; Thorlacius & Olafsson, 2010; Ólafsson, 2012). Unemployment in the 16-24 age group has been higher than among those who are older. Between the years 2003-2008 the youth unemployment rate was 7-8%, increasing to 16% in 2009 and 2010, after which it decreased again. In 2013 the youth unemployment rate was 11% (Statistics Iceland, n.d.).

Inclusion measures for NEET youth

Young people not in employment, education or training (NEET) in Iceland have been the subject of a recent study on transition from school to work (Arnardóttir, 2013, 2014). In 2006 to 2008 they accounted for about 5-6% of the 16-34 age group in Iceland, and the figure rose to 13% in the second quartile of 2009. Before the economic crisis the figure included a higher percentage of women than men. Those who enter lower-skilled jobs at the beginning of their careers, have only completed compulsory education below upper secondary level, or are not Icelandic citizens are more likely to belong to the NEET group than others. This is also the case when the data is controlled to allow for whether they are disabled or not (Arnardóttir, 2014).

Arnardóttir's (2014) study presents various reasons for their inactivity, and concludes that it may be best to have professionals to handle each case on an individual basis; lack of education and lack of job opportunities are nevertheless major factors. Parental education is not predictive of whether young people will be inactive (NEET) or not, although it does affect educational attainment – young people whose parents have low levels of education are more likely to have low levels of education too, while young people who complete tertiary education are likely to have parent/s who have also completed tertiary education.

Carcillo, Fernández, Königs, & Minea (2015) studied the NEET group in the OECD countries since the onset of the financial crisis. Their preliminary findings show that

reducing NEET rates is a great challenge for governments, but it is possible to help some of them with special educational programmes and mentoring.

One way of dealing with inactivity among young people is to invite them to participate in educational programmes and help them to prepare for the labour market. Such inclusion measures have been offered by the Directorate of Labour for those unemployed and recently also for those who receive financial assistance. Of the participants in labour market programmes who received unemployment benefits from the Directorate of Labour in 2010, 4% receiving basic measures were aged 15-19, 36% were aged 20-29, and 60% were 30 years or older. Those aged 30 or older generally formed the majority of participants, but a higher percentage of young people were taking part in vocational training courses, educational contracts and educational activities (see appendix I).

An evaluation of the effects of these programmes in 2011 shows that, among those who had educational contracts, about 87% would leave the unemployment registry (i.e. they were not registered as unemployed for the following 90 days). Those who entered workplaces had the highest success rate of leaving the unemployment registry, 52-82%. However, the success rate for those only participating in basic measures was lower, ranging from 24-31% (Ólafsson, 2012). The results for 2012 are similar (Hannesson, 2013).

Labour market measures for unemployed young people

Iceland was the Nordic country hit hardest by the economic crisis in autumn 2008, and this resulted in a job crisis. The Government responded by offering early intervention, advice, guidance and education as ways of tackling youth unemployment, and more young people participated in special measures than previously; however, only 30% found work in 2009 (Halvorsen, Hansen, Tägtström & Flø, 2013). Since then special programmes have been implemented to tackle increasing unemployment among young people (Hannesson, 2013; Árnason, 2013; Ólafsson, 2012).

Following are brief descriptions of the programmes and how they work.

Youth to Action (I. Ungt fólk til athafna), aimed at young people aged 16-29, offers jobs, educational opportunities, training for specific skills or any other accepted initiative within a period of three months after unemployment registration. Access to various types of education was extended, both within the lifelong learning centres and the formal educational system. By April 2010, all 16-24-year-olds who were registered as unemployed had been invited to participate in the programme (Hannesson, 2013). About 37% of those who participated were not registered as unemployed 90 days after they had completed the programme. According to a survey among those who participated in this programme, 80% were satisfied with the measures they were offered, they believed the measures would help them in the labour market, and felt the measures had a good impact on their mental health. This programme was offered until May 2011.

After May 2011, young people were offered a scheme called 'Job Market' (*I. Atvinnutorg; Sw. Jobbtorg Stockholm*), a project similar to one offered in Sweden. This is a cooperative programme involving the Directorate of Labour and the municipalities. In 2012 about 473 young people participated in this programme, of which 70% were males and 30% females (Eyjólfsdóttir et al., 2013). In the summer 2013 this programme was also offered to those aged 25-29.

Education is a working option (I. Nám er vinnandi vegur) is a special initiative to channel registered, unemployed individuals into education. It started in autumn 2011, but the Government has now stopped funding this project. A total of 1,279 participated in the programme in 18 upper secondary schools. A few dropped out, and one of the main reasons for dropping out was mental health problems (Kristjánsdóttir, 2012).

A working option (I. Vinnandi vegur) was another programme offered in which employers, municipalities and the state created jobs for young people. About 84% of those who participated were not registered as unemployed three months later (Hannesson, 2013). Liðstyrkur is a similar project where the goal is to reach the long-term unemployed and those who are failing to take up unemployment benefits (Hannesson,

2013). An evaluation of Liðstyrkur shows that fewer people applied for the project than expected – only 30% of the registered group. More jobs were created than were needed. Employers were satisfied with the employees from this project and vice versa, and 1,000 participants started work instead of being inactive. Individuals who were more vulnerable, for example because of mental health problems, could not be helped, and a conclusion was that there should have been more collaboration with VIRK, the work rehabilitation centre (Árnason, 2013).

The Directorate of Labour has published annual statistics on the number of participants in active labour market programmes for those registered as unemployed. According to research among those aged 16-29 (Hannesson, 2013) about 19% of unemployed people aged 16-29 participated in 2009, but the proportion rose to 54% in 2010, 53% in 2011, and 43% in 2012. Making participation compulsory for unemployment benefits seemed to activate more youths. The effectiveness of these programmes was measured as 39% in 2009 rising to 46% in 2012, and unemployment also fell as well. Those who completed educational or work-related programmes did better than those who participated in basic programmes or short courses (Hannesson, 2013). Registered unemployment fell among the 16-29 age group, partly because students were not allowed to register as unemployed as from 2010.

Dare – Knowledge and experience (I. ÞOR – Þekking og reynsla) is a programme for long-term unemployed individuals (unemployed for 3 months or more). Participation in Dare was made mandatory and these individuals had to see advisors at the Directorate of Labour and register for some of the programmes on offer; failure to comply could lead to benefit payments being revoked. This was also linked to continuing efforts to seek jobs (Ólafsson, 2012). By the end of 2011, half of the 7,500 individuals aged 30-70 who took part in the programme had found a job or started an educational programme (Agnarsson, 2012).

Stígur is a project offered for those receiving financial assistance. In 2014 participants were 311, 29% younger than 30. Evaluation of the project show promising findings were 68% of the participants got job afterwards (Vinnumálastofnun, 2014).

A survey conducted in December 2014 among individuals who had been registered as unemployed and received unemployment benefits, but were no longer registered, showed that 58% were working, 6% were in education and 22% were still seeking employment. About 27% of job seekers who were no longer entitled to unemployment benefits (having been unemployed for more than three years) were receiving financial assistance from their municipality (Maskína, 2015).

Young people with disabilities participate less in educational programmes than others. Some of them have difficulty accessing buildings and outdoor activities. Lack of education can lead to further obstacles and less experience in preparing for the world of work (Halvorsen et al., 2013). In November 2014, a special programme was introduced by the Directorate of Labour for disabled individuals receiving financial assistance and participating in work rehabilitation in Iceland, called ‘Activate talents – All the talents’ (*I. Virkjum hæfileikana – Alla hæfileikana*). This project is run in collaboration with the Organisation of the Disabled in Iceland (*I. Öryrkjabandalagið*) and the National Federation for Aid to People with Intellectual Disability (*I. Proskahjálþ*).

AMS (*I. atvinna með stuðningi*) is another programme that has been offered to disabled people; 306 people participated in the programme, some of the people retired through disability. This programme is based on the ideology of ‘Supported employment – Place, train, maintain’ (Directorate of Labour, n.d.). AMS is offered in all municipalities in Iceland except one (Samband íslenskra sveitarfélaga, 2014).

The employment rate of people with disabilities is higher in Iceland than in any other OECD country (Ólafsson, 2011a; Hannesdóttir et al., 2010). According to the parliamentary resolution on a plan of action on disabled people’s affairs until 2014, the intention was that about 85% of disabled individuals of working age should have jobs or be involved in measures to increase their involvement, or in appropriate programmes of study, by the end of 2014 (Parliamentary Resolution, 2011). Private organisations and associations now offer rehabilitation programmes; for example, the Organisation of the Disabled in Iceland operates workshops, work rehabilitation centres, such as Hringsjá and Fjölmennt, and offers courses and consultation to study in other educa-

tional institutions. However, the success of the parliamentary resolution has not been tested yet (ÖBÍ, 2011).

Youth community workshops (I. Fjölsmiðjur – D. Produktionsskoler) were first set up in 2001 in Kópavogur, initiated by the Red Cross, and the project is now organised by the municipalities in the capital region, the Directorate of Labour, and the Ministry of Welfare. This project was set up outside the capital region, in Akureyri 2007 and Suðurnes in 2010, in a similar way. The aim is to offer work experience to young people aged 16-24, who are inactive, not in school or working. The project is based on the ‘*produktionsskoler*’ programme in Denmark. The young people sign contracts and engage in light work or workplace-based training in domestic work, car washing, carpentry, and handicraft, and they can study under supervision. The domestic work involves preparing breakfast and lunch for the staff, and employees from other companies can also buy meals there. The young people are paid for their work. There are places for 90 young people in Kópavogur. In 2012 there were 80 individuals participating in Kópavogur, 20 in Suðurnes and 18 in Akureyri. About 80% of those who have participated in Fjölsmiðjan Kópavogi were working or studying afterwards (Hannesson, 2013). The majority of the young people in Kópavogur were aged 16-19; many of them suffered from mental health problems, some had come from the Child Protection Services, and the social services paid for about 15 participants aged 16-17 in the workshop. No formal evaluation of this initiative has been carried out.

CONCLUSION

Mental illnesses are a big problem in Iceland, and have been acknowledged as such in the healthcare system and the social services. There has been systematic discussion between the state, municipalities, and professionals in the mental health services as to the best way of dealing with this problem, and the focus has been on empowering patients. There is, however, a need for more cooperation between services. There is a lack of funding, and more professionals are needed, especially to provide care and services after patients have been treated in hospitals. Nevertheless, the number of psychiatrists per 100,000 of the population is higher in Iceland than in other countries (OECD, 2013).

There are fewer beds for mental health patients in Iceland than there are in Denmark and Norway, and only small numbers of staff are working in the mental health services at Landspítali, which serves the whole country. As the majority of professionals and professional services are situated in the capital region, more needs to be done in the rural areas. Some people working with these patients are concerned about the waiting lists, and more needs to be done to include people with mental illnesses in society. This seems to be of special concern with regards to BUGL and access to psychologists (Embætti landlæknis, 2014a, 2015).

Few studies have focused on the 16-29 age group in Iceland and more information is needed about the extent to which this group needs help, what kind of help is needed, why gender differences occur, and how prejudices and the social isolation faced by these individuals can be prevented. They are more likely than others to be inactive and to drop out of school, and it is difficult to help them through the youth unemployment measures that have been offered. This is a cause for concern.

Few of the people in this group feel that illness hampers their daily lives, which is a good sign, although a higher percentage of young people experience depression than

is the case in Denmark, Finland, Norway and Sweden, and experience anxiety more than is the case in Denmark and Norway. More than half of the 16-19 age group have difficulties concentrating, which can cause problems in school or employment, and this should be another area of investigation.

It is also important that public institutions provide more information about mental health problems among their clients in their annual reports. There should be increased awareness that mental health problems often start at an early age. The social service system should be able to work better on mental health issues, be aware of the importance of preventing poverty, and offer each individual suitable support, education, work and training in a structured way.

Being a part of general activities in society can possibly reduce social isolation and prevent prejudice. The Breiðholtsmódel is an example of how professionals can try to reach out to those in need of their services, and cognitive behaviour therapy may help some of them. Youth community workshops are helping some people, and findings are promising regarding the work-related measures offered by the Directorate of Labour. It is important that programmes and interventions offered are evaluated regularly and objectively by professionals in the field. MST is a treatment that is evaluated and shows positive results and could possibly be developed further. Accessing children and adolescents in Iceland is relatively easy, as more than nine out of ten attend pre-school and school between the ages of two and sixteen.

From this overview it is apparent that some young people are being left behind, and more information is needed to understand their situation. This applies, for example, to those aged 16-17 who are not attending school and cannot apply for unemployment benefits. It is also the case for those who are not registered as unemployed, and those who do not meet the requirements for referral to rehabilitation at VIRK or elsewhere. Evaluation of the results of activation measures is based on whether individuals are registered as unemployed within 90 days after they finish the programme. Is this too narrow a criterion of success? Rehabilitation is needed for longer periods and more young people are in need of such treatment after leaving the child protection services.

The statutory provisions regarding long-term treatment for the disabled are recognised as being a way by which the long-term mentally ill can obtain further support.

There is no particular focus on the 16-29 age group in the national mental health policy and action plan, although many of the proposals might benefit this group. This concerns e.g. proposals on increased services within the health care centres, job offers in public institutions, health promotion in upper secondary schools, suicide prevention/reduction and offering mental health patients suitable residence when they leave the hospital.

Jobs are needed for those who are employable. Transition from school to work needs to be examined closely. Young people leaving the school system and entering the labour market need jobs, suitable training time, and possibly further support to integrate appropriately into the workplace. It could be wise to focus on new entrants and prevent them from being unemployed in the first place instead of waiting for them to register as unemployed or asking for financial support. The goal should be social integration, preventing inactivity and prejudice, and having solutions that are open to all and free of charge. Attention needs to be paid to those who are in the 'grey zone' – i.e. not – i.e. not ill enough to obtain referrals from doctors yet not healthy enough to work with full confidence.

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APPENDIX I

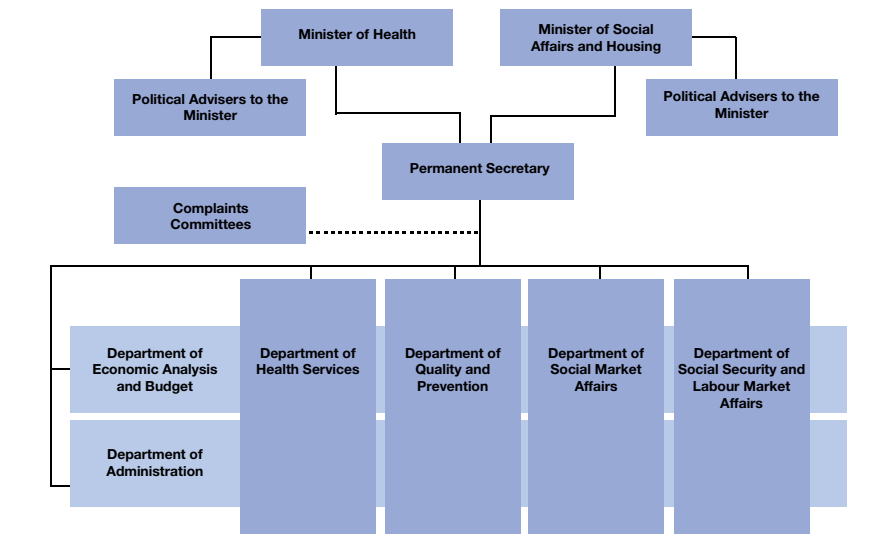


Table 1. Number of patients in mental health services at Landspítali, by age and gender and type of treatment in 2013.

	GENERAL	DRUG ABUSE	REHABILITA- TION	FORENSIC PSYCHIATRY	TOTAL
Total Males	1,370	530	167	34	2,101
10 – 19	33	21	1	0	55
20 – 29	175	112	35	8	330
Others	377	185	41	24	627
Total Females	585	318	77	32	1,012
10 – 19	22	15	2	0	39
20 – 29	230	60	30	1	321
Others	533	137	58	1	729
Total	785	212	90	2	1,089

Source: *Embætti landlæknis* (2014a)

Table 2. Participation in active labour market programmes by type of programme and age in 2010

Age:	BASIC MEASURES		WORK SMITH, ARTWORK, CRAFT WORK		LANGUAGE, COMPUTER, OFFICE TASK		VOCATIONAL TRAINING COURSES		EDUCATIONAL CONTRACTS	
	N	%	N	%	N	%	N	%	N	%
15 – 19	118	4%	92	7%	57	2%	80	6%	22	1%
20 – 29	955	36%	762	60%	1021	38%	814	65%	719	49%
30 +	1589	60%	425	33%	1601	60%	349	28%	739	50%
Total	2662	100%	1279	100%	2679	100%	1243	100%	1480	100%

	ON-THE-JOB TR., EXPERIMENTAL HIRE		SPECIAL PROGRAMMES (I. ÁTAKS-VERKEFNI)		INNOVATION, ENTREPRENEURIAL WORK		FUNDING OTHER COURSES		EDUCATIONAL CENTRE OF SOCIAL PARTNERS	
15 – 19	9	1%	4	1%	11	3%	13	2%	29	4%
20 – 29	278	36%	216	34%	228	53%	265	32%	348	45%
30 +	486	63%	418	66%	192	45%	542	66%	389	51%
Total	773	100%	638	100%	431	100%	820	100%	766	100%

Source: Embætti landlæknis (2014a)

APPENDIX II

The European Social Survey (ESS) is an academically-driven multi-country survey. In the sixth round, it covers 29 countries and employs the most rigorous –ethodologies. It involves strict random probability sampling among all people aged 15 and over, resident within private households. The response rate for Iceland was 55%, for Denmark 49%, Finland 67%, Norway 55%, and for Sweden 53%. In a country comparison it is recommended to use the post-stratification weights (European Social Survey, 2013). This survey data was downloaded from the official homepage and data analysed in SPSS by cross tabulation and Chi-Square test use to test if there are significant differences.

Table 3. Self-perceived mental health/feelings among 16-29-year-olds in 2012

	ICELAND %	DENMARK %	FINLAND %	NORWAY %	SWEDEN %
Subjective general health is good	85.6	85.5	84.7	83.2	88.9
Is hampered in daily activities by illness/ disability/ infirmity/mental problem	17.8	15.1	18.5	16.0	12.5
Felt depressed, some/most of the time in past week (1)	39.1	19.9	18.8	23.3	25.5
Felt anxious, some/most of the time in past week (2)	47.2	30.1	47.4	28.3	44.3
Doing last 7 days: permanently sick or disabled	1.5	0.6	0.8	0.8	0.0

(1) $X^2 (1686, 4)=33.3$ $p<0.001$; (2) $X^2 (1679, 4)=49.5$ $p<0.001$; Source: Own analysis of the European Social Survey 2012 – post-structural weighted figures.

Table 4. Subjective general health among 16-29-year-olds in Iceland, 2012

	VERY GOOD %	GOOD %	FAIR %	BAD %	VERY BAD %	TOTAL %
All	39.2	46.4	12.4	2.0	0.0	100.0
Male	38.6	45.5	11.9	4.0	0.0	100.0
Female	39.8	47.3	12.9	0.0	0.0	100.0

Source: Own analysis of the European Social Survey 2012 – post-structural weighted used

Table 5. Hampered in daily activities by illness/disability/infirmity/mental problem among 16-29-year-olds in Iceland, 2012

	YES A LOT %	YES TO SOME EXTENT %	NO %	TOTAL %
All	1.0	16.8	82.2	100.0
Male	2.0	17.2	80.8	100.0
Female	0.0	16.3	83.7	100.0

Source: Own analysis of the European Social Survey 2012 – post-structural weighted used

Table 6. Felt depressed, how often in past week among 16-29-year-olds in Iceland, 2012

	NONE OR AL- MOST NONE OF THE TIME %	SOME OF THE TIME %	MOST OF THE TIME %	ALL OR ALMOST ALL OF THE TIME %	TOTAL %
All	60.8	34.0	4.6	0.5	100.0
Male	71.0	27.0	2.0	0.0	100.0
Female	50.0	41.5	7.4	1.1	100.0

Source: Own analysis of the European Social Survey 2012 – post-structural weighted used

Table 7. Felt anxious, how often in past week among 16-29-year-olds in Iceland, 2012

	NONE OR AL- MOST NONE OF THE TIME %	SOME OF THE TIME %	MOST OF THE TIME%	ALL OR ALMOST ALL OF THE TIME %	TOTAL %
All	52.9	36.1	9.8	1.5	100.0
Male	59.4	31.7	7.9	1.0	100.0
Female	45.2	40.9	11.8	2.2	100.0

Source: Own analysis of the European Social Survey 2012 – post-structural weighted used

APPENDIX III

Table 8. Hospital treatment in psychiatric units in 2011

Patients treated per 1000:	DENMARK	FAROE	FINLAND	ÅLAND	ICELAND	NORWAY	SWEDEN
Males 15-29	5.5	..	6.1	9.1	6.2	5.7	1.6
Females 15-29	6.5	..	7.8	7.9	5.7	5.6	1.7
All aged 15-29	6.0	..	6.9	8.5	6.0	5.6	1.7
All							
Bed days per 1000	148	291	255	208	90	124	475
Patients treated (N)	24,808	278	26,434	148	1,411	20,498	51,992
Discharged total (N)	47,446	632	41,224	345	2,386	38,043	307,128
Average length of stay per discharged	17.3	22.6	33.4	17.0	..	16.0	14.6
Discharged per capita	8.6	13.0	8	12	7.5	8	33

(1) X^2 (1686, 4)=33.3 $p<0.001$; (2) X^2 (1679, 4)=49.5 $p<0.001$; Source: Own analysis of the European Social Survey 2012 – post-structural weighted figures.

Table 9. OECD data on psychiatrists, mental health nurses, practising doctors, suicides and antidepressant consumption in 2011

	ICELAND	DENMARK	FINLAND	NORWAY	SWEDEN	OECD
Psychiatrists per 100 000 population	22.3	16.9	20.0	20.2	21.9	15.6
Mental health nurses per 100 000 population*	38.0	---	50.1	96.0	56.6	49.7
Practising doctors per 1 000 population*** in 2000	3.44	2.91	---	---	3.09	2.67
in 2011	106	85	70	58	79	59

(1) X^2 (1686, 4)=33.3 $p<0.001$; (2) X^2 (1679, 4)=49.5 $p<0.001$; Source: Own analysis of the European Social Survey 2012 – post-structural weighted figures.

Table 10. Global health Observatory Data Repository on Mental Health in 2011

	ICELAND	DENMARK	FINLAND	NORWAY	SWEDEN
Beds for mental health in general hospitals, per 100,000	42.82	53.91	67.34	---	34.91
Beds in community residential facilities, per 100,000	119.66	---	133.94	---	---
Psychiatrists working in mental health sector, per 100,000	19.74	14.12	28.06	30.77	3.55
Nurses working in mental health sector, per 100,000	37.96	---	---	120.88	28.9
Psychologists working in mental health sector, per 100,000	31.89	---	---	0.45	0.93
Social workers working in mental health sector, per 100,000	10.63	---	---	---	18.42
Community residential facilities, per 100,000	17.31	---	9.02	---	---
Mental health outpatient facilities, per 100,000	2.73	---	2.62	3.6	---
Mental health day treatment facilities, per 100,000	2.13	---	---	---	---
Age-standardised mortality rate (suicide per 100 000 population) in 2012	14.0	8.8	14.8	9.1	11.1
- Males	21.0	13.6	22.2	13.0	16.2
- Females	6.7	4.1	7.5	5.2	6.1
Government expenditures on mental health as a % of total government expenditures on health, in %	8.69	---	3.86	---	10.0

(1) X^2 (1686, 4)=33.3 $p<0.001$; (2) X^2 (1679, 4)=49.5 $p<0.001$; Source: Own analysis of the European Social Survey 2012 – post-structural weighted figures.

Table 11. Percentage of young people aged 16-19 who describe the mental health as very good or good in 2010, and how often they feel

	ÅLAND	DEN-MARK	FINLAND	FAROE ISLANDS	GREEN-LAND	ICE-LAND	NORWAY	SWEDEN
Mental health is good	71.2	77.4	79.1	74.6	73.9	73.8	75.8	75.7
Males	79.7	85.6	84.7	80.1	78.3	78.7	82.9	85.2
Females	59.8	69.0	74.6	69.3	70.5	68.9	70.1	65.8
Felt always, often or sometimes over the last six months:								
difficulty in concentrating?	56.5	62.5	38.2	36.7	49.1	55.2	51.8	68.3
difficulty in sleeping?	54.0	50.4	47.6	41.9	50.6	41.1	50.6	56.6
suffered from headaches?	44.3	42.1	52.3	46.0	42.4	41.1	54.2	45.9
suffered from stomach aches?	32.8	29.7	41.5	43.8	27.9	35.5	46.0	36.1
tense?	41.6	53.5	41.1	32.9	45.0	47.9	62.4	53.5
had little appetite?	27.4	22.9	26.1	26.5	29.1	29.7	36.4	30.8
sad?	40.0	32.6	38.8	49.0	31.4	32.8	60.3	49.8
dizziness?	29.8	23.5	26.6	20.7	22.4	25.2	30.9	32.4

Source: ICSRA, 2010



MINISTRIES AND ADMINISTRATIVE AUTHORITIES

The Ministry of Education, Science and Culture:

<http://eng.menntamalaraduneyti.is>

The Ministry of Welfare

<http://eng.velferdarraduneyti.is>

- Barnaverndarstofa/Government Agency for Child protection: *www.bvs.is*
- Embætti landlæknis/Directorate of Health: *www.landlaeknir.is*
- Greiningar- og ráðgjafarstöð ríkisins/The State Diagnostic and Counselling Centre: *www.greining.is*
- Geðheilsa-Eftirfylgd/Primary Health Care centres: *www.heilsugaeslan.is/onnur-thjonusta/gedheilsa-eftirfylgd/*
- Landspítali/The National University Hospital of Iceland: *www.landspitali.is*
- Tryggingastofnun/The Social Insurance Association: *www.tr.is*
- Vinnumálastofnun/Directorate of Labour: *<http://vinnumalastofnun.is>*
- Umboðsmaður barna/The Office of the Ombudsman for Children: *<https://www.barn.is/>*

MUNICIPALITIES AND REGIONS

Municipalities (74)

Regions (8)

- Samband íslenskra sveitarfélaga/Icelandic Association of Local Authority: *www.samband.is*
- Félagsþjónustur sveitarfélaga/The social services: *<http://www.velferdarraduneyti.is/malaflokkar/fel-sveitarf/>*

RESEARCH

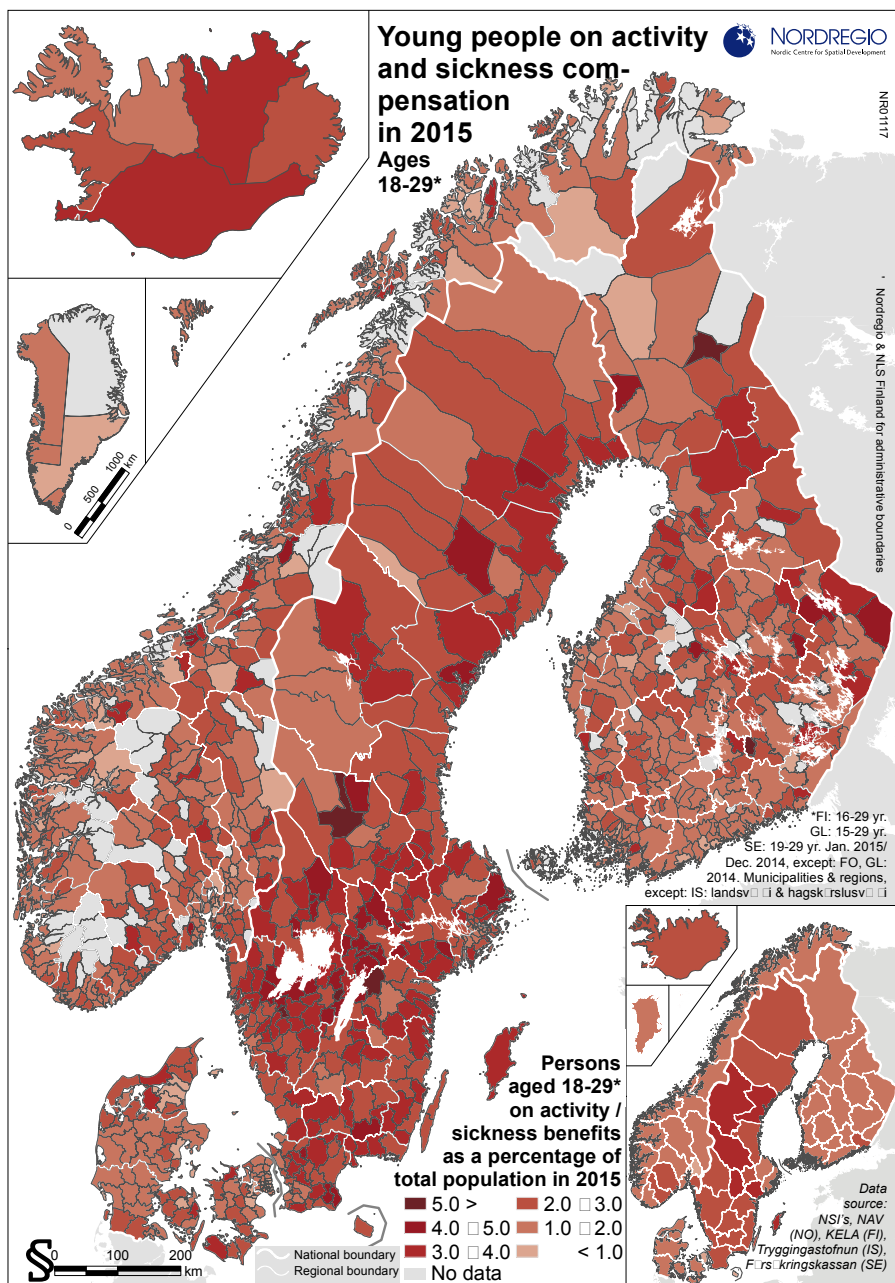
- Félagsvísindastofnun/The Social Science Research Institute: <http://fel.hi.is>
- Rannsóknir & greining/Icelandic Centre for Social Research and Analysis: www.rannsoknir.is
- Þjóðmálastofnun/Social Research Centre, University of Iceland: <http://thjodmalastofnun.hi.is/>
- Rannsóknarmiðstöð Háskólans á Akureyri/RHA University of Akureyri: Research Centre: www.rha.is/en

CIVIL SOCIETY - OTHER

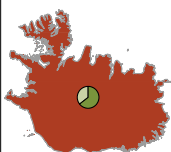
- Reykjalundur/Iceland's largest rehabilitation centre: www.reykjalundur.is
- VIRK/Vocational Rehabilitation Fund: www.virk.is
- Öryrkjabandalagið/Organization of Disabled in Iceland: www.obí.is
- Fræðslumiðstöð atvinnulífsins/Education and Training Service Centre: www.frae.is
- Geðhjálp/The Icelandic Mental Health Alliance: www.gedhjalp.is
- Hring sjá/Rehabilitation center: www.hring.sja.is
- Hugarafl/Psychological counselling: www.hugarafl.is
- Hlutverkasetur/Learning center: www.hlutverkasetur.is
- Janus Starfsendurhæfing/Local learning and rehabilitation center: www.janus.is
- Klúbburinn Geysir/Fountainhouse: <http://kgeysir.is>
- Landssamband æskulýðsfélaga/The Icelandic Youth Council: www.aeska.is
- Rauði krossinn/Red Cross: www.raudikrossinn.is
- Samvinna starfsendurhæfing (MSS)/Learning center: www.mss.is/samvinna-starfsendurhaefing
- Starfsendurhæfing Hafnarfjarðar/Local learning and rehabilitation center: www.stendur.is

- Starfsendurhæfing Norðurlands/Local learning and rehabilitation center: *www.stn.is*
- Starfsendurhæfing Austurlands/Local learning and rehabilitation center: *www.starfa.is*
- Starfsendurhæfing Vestfjarða/Local learning and rehabilitation center: *www.sev.is*
- Birta starfsendurhæfing/Learning center: *www.birtastarfs.is*
- Þroskahjálp/The National Federation for the Aid to People with Intellectual Disability: *www.throskahjalp.is*
- Fjölsmiðjur/Youth community workshops: *www.fjolsmidjan.is*

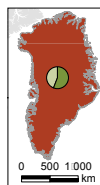
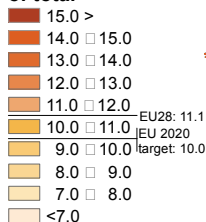




Early school leavers in 2014 by NUTS 2 regions Persons with at most lower secondary education, aged 18 to 24*



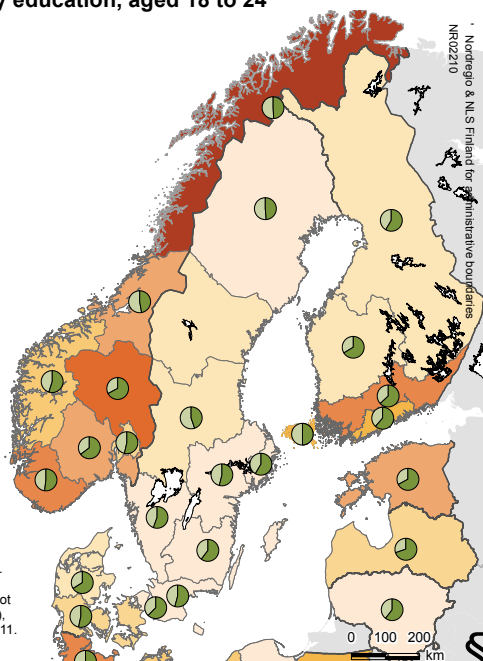
Early school leavers: percentage share of total

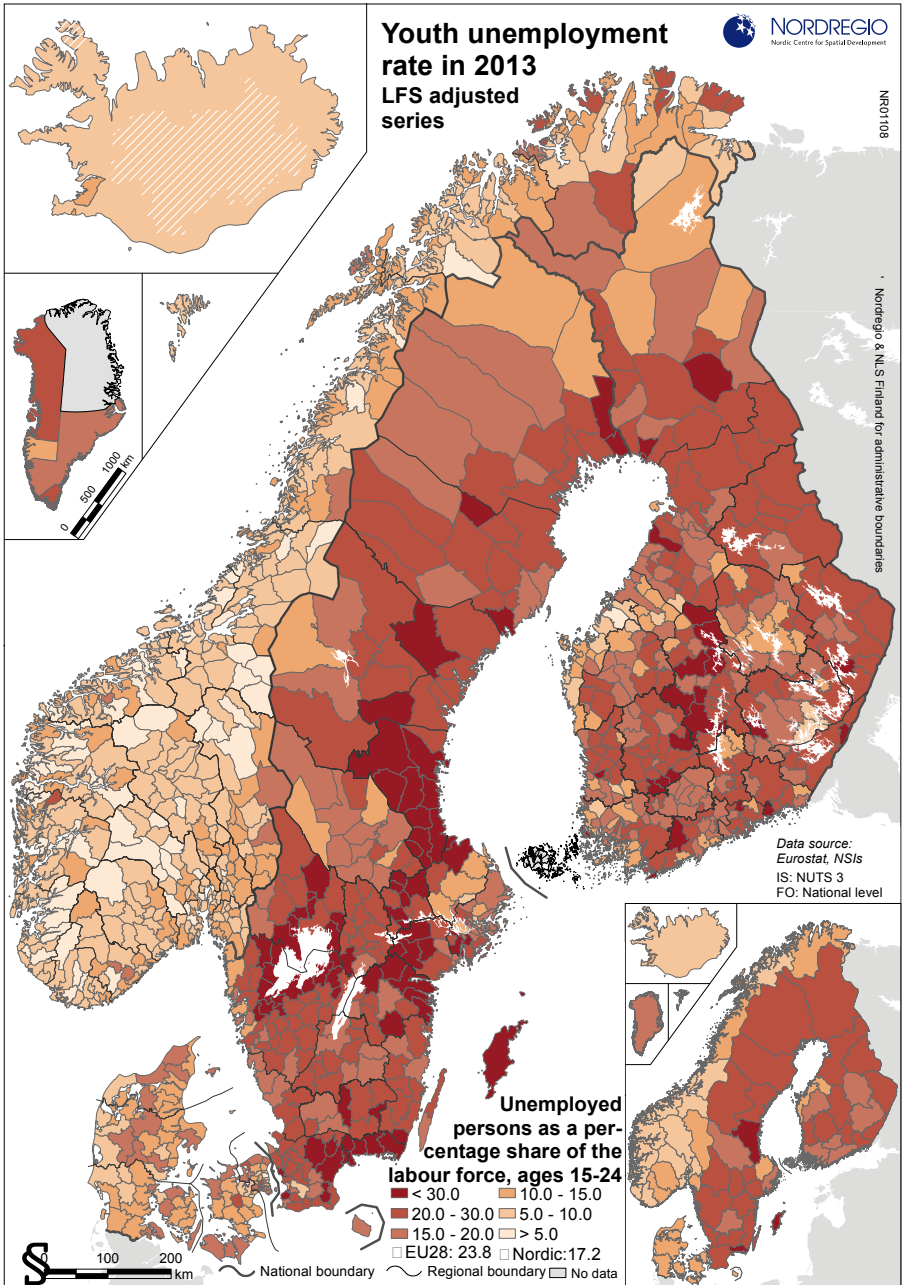


Early school leavers: gender shares

Females Males
EU28:

* Percentage of the population aged 18 to 24 having attained at most lower secondary education and not being involved in further education or training. Regional level: NUTS 2. In EE, IS, LT & LV, NUTS 2 equals national level. AX, GL: estimates. AX: Share of early school leavers probably over estimated, as students studying in Sweden are not included in estimates. SJ: Jylland, Nordjylland (DK), Mellersta Norrland (SE): No gender data. FO: 2011. Source: Eurostat & (for AX, FO, GL) NSI's.

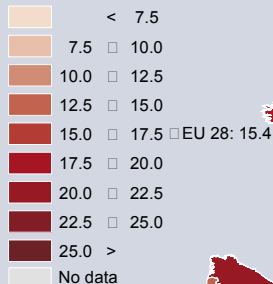




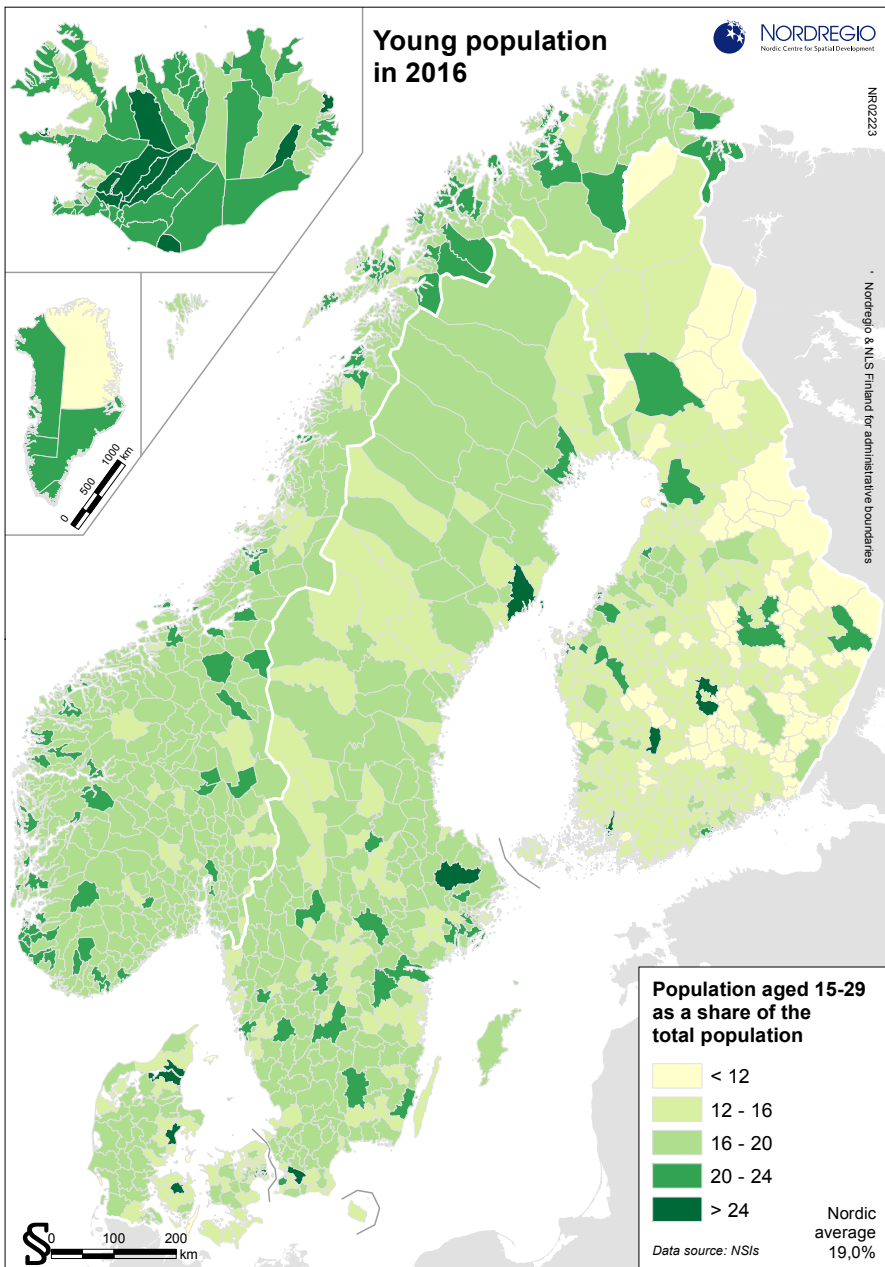
NEET rates in European countries in 2014


Young people neither in employment nor in education and training (NEET)

NEET percentage of total population, ages 15-29



FO: 2011
Source: Eurostat, NSIs



A stylized map of the Nordic region, including Denmark, Finland, Iceland, Norway, and Sweden, set against a blue background. The map is white with black outlines for the coastlines and borders.

The Nordic co-operation involves Denmark, Finland, Iceland, Norway and Sweden, as well as the Faroe Islands, Greenland and Åland.

NORDIC CENTRE FOR WELFARE AND SOCIAL ISSUES – AN INSTITUTION UNDER THE NORDIC COUNCIL OF MINISTERS

Although there are some national differences in the Nordic welfare systems, there are also great similarities between the countries. National differences provide opportunities for comparison and learning from each other's experiences. The Nordic Centre for Welfare and Social Issues is a key-actor in explaining, supporting and developing the Nordic welfare model.

Our work aims at developing strategic input to politicians, compiling research findings and arranging Nordic and international conferences on current welfare issues.

Our focus areas are:

- Welfare policy
- Disability issues
- Labour market inclusion
- Alcohol and drug issues
- Welfare technology

Nordic Council of Ministers

The Nordic Council of Ministers is the official inter-governmental body for co-operation in the Nordic region. The ministers within each specific policy area meet a few times a year to collaborate on matters such as working life issues, social and health policy, and education and research.

Within each policy area, there is also a committee of senior officials, comprising civil servants whose task is to prepare and follow up issues.

Nordic Council

The Nordic Council is the official parliamentary body of the Nordic co-operation. Members of the Nordic Council are members of parliament in the individual countries.

The Nordic Council meets twice a year. The decisions taken at the meetings are implemented by the Nordic Council of Ministers and the Nordic governments. The day-to-day political work is carried out in committees and political party groups.



**NORDIC CENTRE OF WELFARE
AND SOCIAL ISSUES**

**+46 8 545 536 00
info@nordicwelfare.org**

**Find out more about our activity
and our project on our website
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