



Psychiatric Disability Services
of Victoria (VICSERV)

A photograph of a path lined with trees, with the text 'Economic Participation' overlaid. The path is covered in fallen leaves, and the trees are lush green. The text is centered over the path.

Economic Participation



VICSERV Pathways to Social Inclusion

Economic Participation: employment and education – changing outcomes

Facing the facts

- Workforce non-participation amongst people with psychotic disorders is more than 72%
- People with psychiatric disabilities have the highest rate of workforce non-participation compared to other disabilities
- They represent the largest disability group accessing disability employment services (at 30.0%) despite faring worst in employment outcomes
- Unemployment has been found to contribute significantly to the total cost impact of psychosis on the community.

Better outcomes are possible

- Employment has been found to diminish symptoms, reduce hospitalisations and increase independence
- Personal contact with those experiencing mental illness can counter myths and stigma
- Increased participation in meaningful activities by just 10% of unemployed people with psychosis could potentially save around \$147 million per annum
- The goal of realising a vocation in life is a high priority for many people living with severe mental illness.

Our call for action

- A long-term, effectively aligned approach achieved through targeted policy
- Increase the peer workforce (people living with mental illness) in the PDRSS sector
- Better links to employment services, mental health clinical services, PDRSS programs and employment services
- Extend the evidence base for practice.

Economic Participation: employment and education – changing outcomes

*The evidence is in: employment and education are part of the solution!*¹

It is time for increased and better coordinated investment and action that brings together employment, education and mental health agendas to deliver sustainable employment and education pathways for people living with severe mental illness. This will improve mental health and life outcomes.

Employment has been found to diminish symptoms, reduce hospitalisations, increase independence (including financial), improve self-worth and enhance social skills for people living with severe mental illness.

The benefits of employment flow beyond individuals to the wider community. In a work setting, personal contact with those experiencing mental illness can do much to counter myths and stigma.

Unemployment has been found to contribute significantly to the total cost impact of psychosis on the community. Conversely, people with psychosis who are engaged in meaningful activities (such as employment, study or other vocational roles) incur less expense for their condition than non-participants.

Increased participation in meaningful activities by just 10.0% of unemployed people with psychosis could potentially save around \$147 million per annum; if the rate of participation increased by 30.0%, the savings would be around \$441 million per annum.

The number of people with psychotic disorders who are employed increases proportionately with the number of secondary school completions, vocational qualifications, and degree qualifications.

The goal of realising a vocation in life—including, (but not exclusive to) being in a paid job—is a high priority for many people living with severe mental illness.

But our systems are failing to deliver

Workforce non-participation amongst people with psychotic disorders in Australia is more than 72.0%. The latest figures available through the Australian Bureau of Statistics (ABS) indicate that the unemployment rate amongst those with severe mental illness has increased in recent years to 19.5%. (The national unemployment rate at June 2008 was 4.2%.)

¹ Please refer to *Economic Participation: employment and education – changing outcomes, background paper* for details and references.

People with psychiatric disabilities have the highest rate of workforce non-participation compared to other disabilities. They represent the largest disability group accessing disability employment services (at 30.0%) despite faring the worst in employment outcomes (both in securing and retaining work).

We know interruptions to education are due to the particular characteristics of illness onset, which typically occurs in early adulthood. Yet there is evidence of ongoing failure to act to minimise or address the impact of education disruption.

There is a demonstrable relationship between workforce non-participation and interrupted education. One study found 47.8% of the people living with severe mental illness had neither finished their secondary school education nor achieved post-secondary qualifications.

Barriers to employment (and education) are directly related to the symptom profile of low prevalence disorders and the side effects of anti-psychotic (and other) drugs. But there is evidence to suggest that the most significant barriers stem from inappropriate service provision, inadequate support, broader community beliefs and misconceptions about mental illness, as well as the marginalisation those with mental illness experience.

A job seeker with severe mental illness may need to access and coordinate three or more sectors across two levels of government. The challenge of navigating the system can be a profound barrier.

Mental health professionals can have low expectations of the vocational capacities of their patients, mirroring wider societal beliefs that those with psychiatric disabilities are unfit for work. Studies have shown that very few clients are asked about their vocational interests by their mental health workers.

We use some very 'blunt' tools in our program design

- The Job Capacity Assessment (JCA) can paradoxically act as a barrier to positive employment. Because of the episodic nature of serious mental illness, the JCA can under-estimate the assistance needs of job seekers (and refer them to inappropriate employment streams).
- Service capping, e.g. for the Personal Support Program (PSP), Disability Employment Network (DEN), and Vocational Rehabilitation Services (VRS), produces long waiting lists and discontinuity in service provision—both of which are counterintuitive to the rapid job searching approach of evidence-based early intervention approaches. Capping can also mean unsuitable referrals to Job Network. Once 'streamed', there is no easy way to be transferred or to access other programs due to capped places and administrative (bureaucratic) barriers.

- There has been a profound tension between seeking assistance to 'find and try' employment and the risk to the (limited) financial security offered by the DSP.² Consumer concerns are further exacerbated by the need to retain a Health Care Card in order to afford essential medication and access low or no cost health services. The cost of pursuing education (HECS, IT and other expenses) can also be prohibitive. There has been no policy initiative that truly gives incentive and support to employment and education pathways for people living with severe mental illness.
- Many people with severe mental illness require longer-term supports to keep their jobs once the goal of gaining employment has been achieved. The current employment service system does not provide for such supports.
- Education and employment support initiatives lack a focused and proactive approach to working with employers and educational institutions to address stigma and support effort towards inclusion.

Hidden education and employment impacts: carers

On average, carers contribute over 100 hours per week caring for those with mental illness.³ VICSERV is aware that the lives of carers are disrupted and impacted on by the carer and the demands that the episodic and enduring nature of severe mental illness can place upon them. The profile of carers is diverse and includes children, partners, siblings, parents and friends. Different phases and stages of their lives are affected, as carers undertake their role, including education and employment opportunities and outcomes. Yet there is no comprehensive body of knowledge about, or integrated approach to, supporting carers to address their vocational needs and goals.

It is time to recognise that...

The disruption to education and employment in the lives of carers contributes to the total cost burden of mental illness (personal and socio-economic).

Limitations of the mental health service system and the level of social exclusion experienced by people with severe mental illness impact heavily on the lives of carers. These impacts are most often hidden.

We need a sustained and coordinated effort to identify (make overt) and mitigate these costs whilst supporting the vital role carers play in the lives of their loved ones and the mental health service system.

² In July 2008, the Federal Government decided to protect the incomes DSP job seekers. From September 2008, the assessment of pension eligibility will be separated from the assessment of employment assistance needs and people on DSP will be able to have employment assistance needs assessed without fear of losing income in the process. VICSERV supports and welcomes this decision as an important step in a broader process of developing inclusive policy.

³ See *Social Inclusion – An Outcome Measure for the Mental Health Service System. Notes on Context, Definition and Evidence* for details.

We have evidence about approaches that produce better employment outcomes

An approach that better integrates specialist employment services with mental health and Psychiatric Disability Rehabilitation and Support Services (PDRSS)—specialised supported employment or Individual Placement and Support—improves employment outcomes for 40-60% of participants. Features of specialised supported employment that make a positive difference to outcomes for people living with severe mental illness are:

1. Eligibility for employment services, based on consumer choice, not job readiness.
2. Integration of disability employment services with mental health care.
3. The goal of competitive or open employment.
4. Rapid commencement of job searching activities.
5. Job placements based on consumer preferences, strengths, experience, and interests.
6. Continuing support to retain employment.
7. Income support and benefits counselling.
8. Continuous availability of intensive onsite workplace support.
9. Multidisciplinary teams to coordinate treatment and vocational interventions.
10. Alliances between staff and consumers in rehabilitation.
11. Strategies to counter workplace stigma.

There is also emerging evidence that supported education programs (with comparable support features) work, and ultimately contribute to, improved quality of life and better employment outcomes.

From rhetoric to action: a rights-based, coordinated approach

Australia is a signatory to the United Nations *Covenant on Economic, Social and Cultural Rights*. We have committed to recognising the rights of everyone to opportunities to gain their living through work that is freely chosen, and to taking appropriate steps to safeguard these rights. It is time to make that commitment a reality for people who experience severe mental illness.

There is a need for a specific education and employment policy and strategy (including investment) for people with serious mental illness that:

- Considers and responds to the nature of mental illness.
- Takes into account different age cohorts and related needs.
- Offers income security over extended time periods.
- Protects Health Care Card holder status and access to medication and health services.
- Addresses stigma.
- Coordinates and links education and employment support to mental health (clinical and support) responses.

The VICSERV proposition: targeted policy, immediate action⁴

There is a need for immediate action to address the barriers to employment and education experienced by people living with severe mental illness. There is a need for considered, integrated policy that focuses on the long term. It is also necessary to recognise and respond to the impacts of caring on the capacity for economic participation of carers.

The ageing of the population provides further imperatives to build more inclusive work environments and to increase the number and range of opportunities for people with mental illness to engage in meaningful work.

It is both important and timely to extend the body of knowledge about 'what works' in relation to effective employment and education programs for people living with severe mental illness and their carers, while remembering the different life stages and cohorts in each.

The VICSERV propositions involve a (necessarily) multi-faceted approach and suggest both immediate and longer-term actions. The propositions include:

⁴ VICSERV is aware and supportive of the current (Commonwealth) review of employment services and will further develop and refine elements of this proposition in response to improvement and opportunities arising from this work.

1. Long term: an effectively aligned approach achieved through targeted policy

VICSERV actively encourages the formation, by agreement of State and Commonwealth Governments, of a broad based working party to develop an integrated and coordinated *Education and Employment Policy/Strategy for People Living with Mental Illness*. The initiative must have the capacity to influence, over time, a broad range of departments, policies, systems and processes across jurisdictions in order to achieve better outcomes for people living with severe mental illness. It is important that this initiative incorporates or links to approaches that have been shown to be of value through work undertaken in the broader disability field. To make the necessary difference, however, this initiative must be specifically targeted to addressing the needs of people with severe mental illness.

Investment required: the initial investment is not in additional funds but in the dialogue and leadership necessary to build commitment and agreement to establishing a joint change agenda and working party. VICSERV will actively lend its voice and support to promoting a partnership between Commonwealth and State Governments and peak community and welfare organisations to build that agreement.

2. Actions to 'make a difference now'

Action 2.1 A new model of support

People living with severe mental illness who are attempting to engage in education/training or employment related activities require long-term, individualised support. Neither the PDRSS nor employment service sectors are currently geared up (or appropriately funded) to provide such support. Other than crisis services, mental health services are almost exclusively offered during business hours.

It is critical that the PDRSS sector is partly reoriented to recognise, encourage and support consumers to achieve their education and employment goals. This means extension of State-funded PDRSS (and/or selected Commonwealth initiatives) service hours to include after hours support options that are not crisis focused.

It is proposed that the Department of Human Services (DHS) Mental Health Branch and VICSERV work in partnership to further detail a conceptual model and indicative cost to inform a 'flexible hours support program' targeted toward consumers engaging in employment and/or education initiatives. There is potential for this work to feed into the proposed evaluation of the Commonwealth Personal Helpers and Mentors Program and, importantly, into current work on mental health service system reform in Victoria.

Investment required: \$20,000 seed funding (and/or linkage to comparable work in progress). VICSERV will contribute in-kind research expertise to an equivalent value. This work should be initiated and completed within the shortest possible timeframe. It is anticipated that there will be a requirement to redirect and increase investment in the PDRSS sector. This will need to be linked to housing and education outcomes once the initial work is completed.

Action 2.2 Building the peer workforce within the PDRSS sector

There is enormous potential to increase the peer workforce (people living with mental illness) in the PDRSS sector in the short-to-medium term. The benefits of a strong peer workforce include:

- Role modelling for consumers—confirmation of aspiration and hope.
- Provision of 'safe' initial employment pathways for people with severe mental illness.
- Better understanding of work environments and practices that are supportive of people with severe mental illness.
- Capture of evidence to challenge perception and stigma.
- Development of management and support models transferable to the broader (community) service sector.
- Learning for professionals working as colleagues and managers.

In order to achieve this type of workforce expansion, the PDRSS sector requires investment to:

- Support culture change and enhancement.
- Redesign (some) positions and structures.
- Enhance management and supervision skills.
- Foster, recruit and support additional peer workers.
- Evaluate effort over time—share good practice.

VICSERV proposes piloting a *PDRSS Peer Workforce Initiative* in six selected sites across Victoria. Pilot sites are intended to reflect diversity within the sector and will receive organisation development grants (ODG) over a two-year period. ODG would be tied to:

- Specific 'peer' employment targets.
- Organisational change and development goals.
- Participation in longer-term evaluation.

There needs to be exploration of the issues of peers' rights to privacy and management of disclosure as part of developing and implementing the pilot. Evaluation of workplace changes within the pilot sites and the experience of peers is seen to be integral to the pilot and a means to promote longer-term change across sectors.

It is proposed that the pilot be a joint initiative of DHS and the Department of Planning and Community Development. There may also be potential to seek to Commonwealth contribution. VICSERV would seek to be actively engaged in the design of the pilot and would recommend strong engagement with consumer bodies with knowledge of peer workforce initiatives.

Investment required: \$100,000 per pilot site per annum for two years (\$1.2 million) plus \$120,000 for pilot evaluation, (\$1,320,000 over two years).

Action 2.3 Leveraged partnerships and better integrated responses

There is a need to better link employment services, mental health clinical services, PDRSS programs and employment services. This process can be assisted by 'better tools', including:

- Stronger emphasis on vocational goals in treatment and recovery plans. This approach could be actively fostered through Mental Health Alliances without additional investment.
- Funding and service agreement/contract inclusions that require demonstrated partnership and linkage between sectors. DHS could consider opportunities to achieve this as part of the *Because Mental Health Matters* policy development, however, broader change would need to be linked to the proposed *Education and Employment Policy/Strategy for People Living with a Mental Illness*. No additional investment is required.
- Job Capacity Assessment processes that allow for/encourage 'mental health' expert input into the types of support most congruent with consumers' experience of mental illness. This would require an agreed definition of the target group and mental illness. VICSERV is aware that current review processes at the Commonwealth level may provide useful forums where agreement on necessary change could occur. It would also be necessary to link this

discussion to the question of expert resource availability and ensure state-based policy makers and clinical and support service providers are engaged.

Investment required: there is likely to be some additional investment required to ensure 'mental health' expert input is available in a timely manner. The extent and source(s) of funds/expertise would need to be determined through broad-based discussion, and the Commonwealth/MBS Mental Health Nurse initiative could be considered as an option.

3. *Professional education and built capacity to address stigma in workplace/education settings*

There are two aspects to this initiative

(a) *'Enabling employment and education' training* for mental health professionals, employment service providers and educators to assist in bringing about the attitudinal change across sectors necessary to ensure the effective inclusion of people living with severe mental illness in employment and education. The training would include the transfer of technical knowledge as well as challenge attitudes and myths that work against supporting people living with a mental illness to achieve their employment and education goals.

(b) It is proposed that VICSERV works in collaboration with members and selected providers (employment, clinical mental health, and education) to develop and pilot a training package and train-the-trainer modules over a 12-18-month period.

Investment required: \$60,000 for training package(s) and pilot.

(c) *A proactive approach to working with employers to better understand mental illness and support workplace inclusion*

This initiative involves the two-year pilot of a 'Workplace Ready Team' including mental health and employment service professionals and consumer/peer workers. The team would work with a range of employers to support the active inclusion of people with a mental illness in the workplace and link those employers with employment services. The team would provide intensive assistance to an organisation for an agreed and fixed period of time offering staff and management education programs, assistance to design or redesign positions, and assistance in the development of workplace policies that support inclusion. The team would also explore the possibility of developing some form of 'inclusive practice award' program integrated into mainstream business awards events.

Investment required: two year pilot at \$300,000 per annum (a total of \$600,000). There is potential for this initiative to attract funding contribution from VicHealth and other bodies as well as from State and Commonwealth Government levels. The initiative may be designed to dovetail with other relevant workplace reform initiatives.

4. *Extending the evidence base for practice*

VICSERV proposes two distinct research projects specifically designed to build the evidence base for practice. These are:

Project 1: Education: experience, aspirations and outcomes study

It is critical to develop a better understanding of the short and long term experience of people whose education trajectories are disrupted by mental illness in order to improve the timing and nature of supportive interventions. It is proposed to design and undertake an *Education: Experience, Aspirations and Outcomes Study* involving a significant-sized group of mental health consumers of both clinical and PDRSS services (in Victoria) who represent a diversity of the 'illness' experience, as well as an age, gender and cultural mix.

The study will explore the impact of mental illness on the consumers' educational experiences, as well as on education outcomes and the consequent impact on employment. It is intended that this study involve collaboration between consumer representatives, clinical service representatives, DHS and VICSERV (and its members). It is likely to be of additional value to engage representatives of other (relevant) Government departments as well as employment service provider peak bodies to a Project Reference Group. It is expected a credible research body would be contracted to design and undertake the research.

Investment required: \$30,000 to design the research and an additional \$90,000 to complete the project. It is anticipated the work could be completed within a 12-18-month timeframe.

Project 2: Impact study of caring on employment and education

The impact of caring for people living with severe mental illness on the employment and education opportunities and outcomes of carers is an issue that is neither adequately understood nor responded to. Given the range of people engaged as carers—children, partners, siblings, parents and friends—VICSERV proposes a staged approach to understanding and responding to the impact.

Initial effort would include building a partnership of the diverse group of stakeholders able to bring the necessary breadth of knowledge and awareness to the table to scope a viable research project (including literature review). VICSERV proposes partnering with selected peak organisation(s) and DHS to initiate this work.

Investment required: \$60,000 in Year one to build the research partnership, complete the necessary literature review and scope/design the research. The full requirement for investment would be identified in Year one.

Summary of proposed investments

Strategy Element	Initiative	Year 1	Over 3 Years	Funders and Contributors	Outcomes
Targeted Policy	Education and employment – inter-sectoral alignment, targeted policy and strategy	No additional resources, commitment leadership and dialogue	Not known	Leadership + participation at C'wealth and State levels	An aligned change agenda that supports education employment outcomes
Actions to Make a Difference Now	New model of support: 'flexible hours support program'	\$20,000 in seed funding, VICSERV in-kind contribution (equivalent value)	To be determined	DHS Mental Health Branch and VICSERV	Tailored support model that enables consumers to achieve better education and employment outcomes
	Peer workforce	\$100,000 x 6 + \$60,000 (evaluation) = \$660,000	(Year 2) \$100,000 x 6 + \$60,000 (evaluation) = \$660,000	DHS, DPCD, VICSERV (and members) and others	Expanded peer workforce, good (OD) practice models
Organisational Capacity Building	Training Program: Enabling Employment and Education	\$60,000	-	VICSERV and members, selected providers	Attitudinal change amongst professional and a training resource for ongoing use
	Workplace Ready Team	\$300,000	\$300,000	C'wealth and State Governments VicHealth, VICSERV, Employment Services	Increased number of employers, committed and ready to provide sustainable employment for consumers
Evidence-Based Practice	Education: Experience, Aspirations and Outcomes Study	\$30,000 to design	\$90,000 to complete	DHS, VICSERV, consumers and others	Increased understanding of how to build capacity for better educational outcomes
	Impact Study of Caring on Employment and Education	\$60,000	To be determined	DHS, VICSERV and Carer organisations	Increased understanding of the impacts of the role of carer on education and employment

The benefits of employment

The benefits of employment for people living with severe mental illness are well documented. In their report on employment and psychosis for the *National Survey of Mental Health and Wellbeing*, Frost et al. argue that aside from providing opportunities to contribute economically and socially to the community, employment can also assist in the journey of recovery.¹ Citing numerous studies, the authors write that employment has been found to diminish symptoms, reduce hospitalisations, increase independence (not just financially), improve self-worth, and enhance social skills. The authors conclude that:

*Employment is not only a necessary condition for truly independent community living but also a platform from which people with chronic mental illness can obtain the rewarding aspects of mainstream living that most people take for granted.*²

Waghorn and Lloyd similarly refer to a number of studies that identify the benefits of employment for people living with severe mental illness.³ Employment is linked to improved self-concept and self-efficacy, higher rates of self-reported wellbeing, a regaining of self-esteem and personal empowerment, and reduced clinical symptoms. Employment gives people with severe mental illness structured time and routine, opportunities for social contact and participation, a sense of collective effort and shared purpose, increased social identity and status, and a feeling of personal achievement. In addition, the benefits of employment flow beyond the individual to the wider community. Personal contact with those experiencing severe mental illness in the workplace can do much to counter the myths and stigma associated with mental illness in mainstream society and raise awareness of the issues, difficulties and disadvantages experienced by those living with low prevalence disorders.

One other way to consider the benefits of employment is to look at the negative impacts of unemployment. According to Bill et al., unemployment has negative consequences for anyone in terms of self-confidence, competence, integration, responsibility and freedom.⁴ It leads to financial precariousness, poor quality of life, poverty and isolation. It is, in short, a form of marginalisation and exclusion. But unemployment does not affect the community evenly. Amongst those hardest hit are people living with severe mental illness, further compounding a range of unmet needs due to socio-economic disadvantage.

At a broader level, unemployment has been found to contribute significantly to the total cost impact of psychosis on the community. In their study on the costs of psychosis, Carr et al. found a strong association between employment and a reduced cost burden borne by society,

¹ Frost B, Carr V and Halpin S (2002) *Employment and Psychosis*, National Survey of Mental Health and Wellbeing Bulletin 3, Canberra: Mental Health Branch, Commonwealth Department of Health and Ageing, pp. 1-2.

² *Ibid.*, p. 5.

³ Waghorn G and Lloyd C (2005) *The Employment of People with Mental Illness*, Discussion Document, Marlestone SA: Mental Health Fellowship of Australia, pp. 14-15.

⁴ Bill A, Cowling S, Mitchell W and Quirk V (2004), *Creating Effective Employment Solutions for People with Psychiatric Disability*, Working Paper No. 04-06, Centre of Full Employment and Equity, Callaghan: University of Newcastle, pp. 10-11.

including government.⁵ People with psychosis who are engaged in meaningful activities (such as employment, study or other vocational roles) incur less expense for their condition than non-participants. In other words, there may be real cost benefits to the community in increasing rates of participation in meaningful employment (commensurate with abilities and interests) for those with psychotic disorders. Indeed, Carr et al. estimate that increased participation in meaningful activities by just 10% of unemployed people with psychosis could potentially save society around \$147 million per annum in costs. If the rate of participation increased by 30%, the savings would be around \$441 million per annum. There are net cost benefits even if the investment in rehabilitation programs required to improve participation rates is taken into account—particularly for a 30% improvement.⁶ Along with the benefits that employment brings at the individual level, it makes economic sense to the community as well.

Demographic trends provide another compelling economic argument for the employment of people with severe mental illness. According to the Australian Chamber of Commerce and Industry, current fertility and migration rates will not offset the impact of a shrinking workforce as 'baby boomers', retiring in the next decade or two. The workforce currently grows by about 180,000 people per year; but in just 12 years time, and for the decade 2020 to 2030, that figure will fall dramatically to 18,000 per year. Productivity, gross domestic product, and standards of living, are all likely to be affected by this trend unless policies are put in place now.⁷ People with severe mental illness currently represent an under-utilised and untapped segment of the labour market and could potentially become part of a national workforce strategy for our ageing population.

Workforce non-participation and unemployment

Despite widespread agreement on the benefits of employment and (conversely) the harmful consequences of unemployment, there is still much to be done to give people living with severe mental illness real opportunities to achieve and maintain paid work. The reality is that for many in this group, the prospects of secure employment are a distant proposition. Chronic unemployment resulting in increased welfare dependency, poverty, socio-economic disadvantage, and associated unmet needs are the abiding features in their lives.

The workforce non-participation rate of people living with severe mental illness was captured through a census of 3,800 Australians aged 18-64 with psychotic disorders undertaken by the Low Prevalence Study Group of the *National Survey of Mental Health and Wellbeing*.⁸ The research method included interviews with 980 participants using a specifically designed instrument covering socio-demographic details such as participation in paid work. The research found that 72% of participants could not describe a regular occupation (whether paid work, study or unpaid work) at the time of the interviews; and that this was the case for 58.3% of participants for the 12-month period leading up to the study. Indeed, in the 12-month period

⁵ Carr V, Neil A, Halpin S and Holmes S (2002) *Costs of Psychosis in Urban Australia*, National Survey of Mental Health and Wellbeing Bulletin 2, Canberra: Mental Health Branch, Commonwealth Department of Health and Ageing, p. 33.

⁶ *Ibid.*, p. 34.

⁷ 'Baby boomers' retirement has dire consequences', *ABC News*, posted 23/07/08 7:14 a.m. AEST, available at <http://www.bananasinpyjamas.com/news/stories/2008/07/23/2311523.htm> and accessed 31/07/08.

⁸ Jablensky A, McGrath J, Herrman H, Castle D, Gureje O, Morgan V and Korten A (1999) *People Living with Psychotic Illness: An Australian Study 1997-98*, National Survey of Mental Health and Wellbeing Report 4, Canberra: Mental Health Branch, Commonwealth Department of Health and Ageing. This study was part of the first National Survey of Mental Health and Wellbeing. The second National Survey of Mental Health and Wellbeing was conducted in 2007 with preliminary results available in late 2008.

prior to the interviews, only 9.8% reported regular full-time work. Not surprisingly, only a small proportion (15.5%) reported financial independence through income drawn from wages or salary, with the majority (85.2%) in receipt of a government pension or social benefit (in particular the disability pension) as their main income source.⁹

Waghorn and Lloyd estimate that the rate of workforce non-participation amongst people with psychotic disorders in Australia is actually around the 75-78% mark, compared to 75-90% in the USA and 61-73% in UK.¹⁰ According to the Mental Health Council of Australia (MHCA) this means only two in ten Australians with a psychotic disorder are currently in some form of employment.¹¹ The MHCA also draws on the ABS *1998 National Survey of Disability, Ageing and Carers* to show that people with psychiatric disabilities have the highest rate of workforce non-participation (71.2%) compared to other disabilities (these being intellectual, head injury/stroke/brain damage, sensory and physical).¹² More up-to-date figures released by the Australian Safety and Compensation Council (ASCC) and using a slightly different nomenclature of disability types reveal an overall workforce non-participation rate of 73.6% amongst people with disability due to mental illness, second only to the rate for people with disability due to 'nervous and emotional condition' (76.3%).¹³

According to the latest figures available through the ABS, the unemployment rate amongst those with severe mental illness has increased significantly since the *1998 National Survey of Disability, Ageing and Carers*.¹⁴ In 1998, the unemployment rate was 7.2%; in 2003, it was 19.5%, the highest of all disability types.¹⁵ Meanwhile, the unemployment rate for the population overall has fallen during the last ten years; at June 2008 the rate was 4.2%.¹⁶ Consistent with the figures above, the workforce non-participation rates for people with severe mental illness have more or less stayed the same (71.8% in 2003) suggesting that of those non-participating, it is the impetus to be in paid employment that has changed between these two periods.

Whatever the figures used, the undeniable point is that there is a high rate of workforce non-participation in this group and a high rate of unemployment. Yet, the goal of realising a vocation in life—including, but not exclusive to, being in a paid job—remains a high priority for many with severe mental illness.¹⁷ In the final report of their national inquiry into the human

⁹ Ibid., p. 43.

¹⁰ Waghorn and Lloyd op. cit., p. 4.

¹¹ Mental Health Council of Australia (2007) *Let's Get to Work: A National Mental Health Employment Strategy for Australia*, Deakin ACT: Mental Health Council of Australia, p. 17.

¹² Ibid., p. 18.

¹³ Australian Safety and Compensation Council (2007) *Are People with Disability at Risk at Work? A Review of the Evidence*, Canberra: Department of Education, Employment and Workplace Relations, p. 66.

¹⁴ The non-participation rate includes people who have retired, are studying, or occupied in activities that encompass unpaid work (e.g. care of children). The unemployment rate, as opposed to the non-participation rate, is the rate of those in the population not participating in the workforce and actively looking for work.

¹⁵ The figure for 1998 is from the ABS *1998 National Survey of Disability, Ageing and Carers* as cited in Mental Health Council of Australia, op. cit., p. 18. The figure for 2003 is from the Australian Bureau of Statistics (2004) *Disability, Ageing and Carers: Disability and Long Term Health Conditions, Australia 2003*, Table 17, Cat. No. 4430.0.55.002, Canberra: Australian Bureau of Statistics, available at

<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4430.0.55.0022003?OpenDocument> and accessed 08/07/08.

¹⁶ Australian Bureau of Statistics (2008) *Labour Force Australia, June 2008*, Cat. No. 6202.0, latest issue released at 11:30 a.m. Canberra time 10/07/08, available at <http://www.abs.gov.au/AUSSTATS/abs@.nsf/mf/6202.0> and accessed 31/07/08; Commonwealth of Australia (2008) *Employment Assistance for People with Mental Illness: Literature Review*, Canberra: Department of Education, Employment and Workplace Relations, p. 14.

¹⁷ Frost et al., op. cit., p. 7.

rights of people with mental illness, the Human Rights and Equal Opportunity Commission (HREOC) found discordance between the importance of paid work in people's lives and its actual achievement.¹⁸ Waghorn and Lloyd similarly suggest that high unemployment rates in no way imply unwillingness to work or the unfeasibility of gaining employment. This is borne out in recent research, which shows that people with psychiatric disabilities represent the largest disability group accessing disability employment services (at 30.0%) despite faring the worst in employment outcomes (both securing and retaining work).¹⁹ Other studies show that people living with severe mental illness continue to strive to find a meaningful vocational place for themselves in society, as workers, students, volunteers, consumer advocates, parents, homemakers, etc.²⁰ With appropriate supports, it is possible to include vocational options as part of their rehabilitation plan; and indeed, many people living with severe mental illness go on to achieve their vocational goals including employment.

As pointed out by MHCA, Australia is a signatory to the United Nations *Covenant on Economic, Social and Cultural Rights*.²¹ Article six states that those party to the Covenant will recognise the rights of everyone to opportunities to gain their living through work that is freely chosen, and will take appropriate steps to safeguard these rights (including policies, training and guidance). Whilst several mental health strategies across Australian jurisdictions exist that reflect the principles contained in the Covenant (e.g. the Council of Australian Governments (COAG) *National Action Plan on Mental Health 2006-2011*) the workforce non-participation and unemployment rates experienced by people with severe mental illness suggest that rhetoric has not translated into outcomes for this group.

MHCA go on to add that what is needed is a dedicated employment strategy for people with mental illness; here echoing the findings from the 2005 final report of the HREOC *National Inquiry into Employment and Disability*.²² The HREOC report recommended a nationally led initiative to increase workforce participation amongst those with disabilities through the development of a mental health employment strategy. Since the last federal election, and under the banner of the new social inclusion agenda, there are promising signs that something is starting to take shape. There is currently a process in place for developing a *National Mental Health and Disability Employment Strategy* and a parallel review of publicly-funded employment services.²³

¹⁸ Human Rights and Equal Opportunity Commission (1993) *Report of the National Inquiry into the Human Rights of People with Mental Illness*, Canberra: Human Rights and Equal Opportunity Commission, as cited in Bill et al. op. cit., p. 10.

¹⁹ Waghorn and Lloyd, op. cit., p. 4.

²⁰ Ibid., pp. 13-14.

²¹ Mental Health Council of Australia, op. cit., p. 5.

²² Ibid., p. 16. Indeed, the MHCA paper was written in the absence of a national employment strategy for people with mental illness. See also Human Rights and Equal Opportunity Commission (2005) *WORKability II: Solutions, People with Disability in the Open Workplace*, Final Report of the National Inquiry into Employment and Disability, Sydney: Human Rights and Equal Opportunity Commission.

²³ Commonwealth of Australia (2008) *National Mental Health and Disability Employment Strategy*, Discussion Paper, Canberra: Commonwealth Government Department of Education, Employment and Workplace Relations; and Commonwealth of Australia (2008) *The Future of Employment Services in Australia*, Discussion Paper, Canberra: Commonwealth Government Department of Education, Employment and Workplace Relations.

Education as a pathway to employment

There is evidence to show that levels of educational attainment are strongly associated with rates of workforce participation amongst people with severe mental illness. According to Waghorn and Lloyd, the number of people with psychotic disorders who are employed increases proportionately with the number of secondary school completions, vocational qualifications, and degree qualifications.²⁴ Conversely, the high rate of workforce non-participation in this group is related to a high rate of interrupted education. The research by the Low Prevalence Study Group found that almost one half (47.8%) of participants had neither finished their secondary school education nor achieved post-secondary qualifications.²⁵

Interruptions to education are due to the particular characteristics of illness onset, which typically occurs in early adulthood during a critical time of education completion and early career preparation. Again, from the Low Prevalence Study Group research, the average age of illness onset amongst participants was found to be from 24 to 25.²⁶

For those who become unwell during secondary school, there is often very little by way of support to enable them to continue studying. Indeed, our education system may be unwittingly facilitating the rates of non-completion of compulsory education amongst this group. As put by one teacher:

Our core business is education – we identify children with intellectual disability but not psychiatric disability. We are not funded to support these kids. We can provide inclusive resources but we can't really do it properly. Generally they are just piece meal packages ... I have staff using the expulsion/suspension guidelines to exclude these kids. Actually, they really need care.²⁷

Despite the low levels of educational attainment amongst people with severe mental illness, the goal of achieving an education—like employment—remains a high priority for many. For example, a Western Australian study on vocational education and training involving 26 people with a psychiatric disability found that around three-quarters of participants wanted to undertake educational activities as one of their priorities in life.²⁸ Yet, people with severe mental illness continue to be under-represented in vocational education and training systems, suggesting barriers to restoring educational trajectories. These barriers are discussed further below (see 'Barriers to Restoring Educational Trajectories').

²⁴ Waghorn and Lloyd, op. cit., 11.

²⁵ Jablensky et al. op. cit., p. 32.

²⁶ Ibid., p. 10.

²⁷ Mental Health Council Australia (2005) *Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia*, Canberra: Mental Health Council Australia, p. 180.

²⁸ Pathways to Opportunities Program, Ruah Inreach (2004) *People Living with Mental Illness and Vocational Education and Training*, Perth: Government of WA Department of Education and Training, p. 30.

Barriers to employment

Clearly, we could be doing much more to support people living with severe mental illness to realise their vocational aspirations, particularly with respect to employment. Understanding the barriers to workforce participation will help inform any strategies for improving outcomes. Whilst some barriers to employment are directly related to the symptom profile of low prevalence disorders and the side effects of anti-psychotic (and other) drugs, there is evidence to suggest that the most significant barriers stem from inappropriate service provision/support, broader community beliefs and misconceptions about mental illness, and the marginalised place given to those with mental illness in our 'age of reason'. These 'indirect' barriers are modifiable, albeit intransigent, and can therefore be the focus for change.

In discussing barriers to employment, it is important to keep in mind a 'life stages approach' and three broad cohorts with very different needs. The first group includes younger people whose diagnosis came at a time when a vocational direction was being established. Re-engagement with this direction would be the issue here. The second group includes those who are older and whose diagnosis interrupted an established career. People in this group are likely to have a skills set and employment experience base to draw on during their rehabilitation, however, may need support reorienting their career in light of their mental illness. The third group includes those who are older, perhaps with a history of institutionalisation, and who have never established a vocational direction or are temporarily removed from their original vocational path. The needs of this group are potentially much more complex than the other two.

Disrupted vocational trajectory

An interrupted education leads to a disrupted vocational trajectory and longer-term consequences for restoring direction, e.g. loss of confidence and difficulty in identifying vocational goals.²⁹ An interrupted education can also lower vocational expectations, limit career prospects, displace one 'downwards' to less-skilled jobs or into part-time jobs when full-time work is sought (underemployment), and precipitate instantaneous unemployment that has the potential to become long term.³⁰ These add up to significant barriers in terms of achieving meaningful employment.

Limitations through symptoms

The symptoms of severe mental illness typically manifest as impairment, functional limitation or role restriction that vary considerably across time.³¹ There may be periods of good functioning that fluctuate with levels that are less than optimal. It is the course of severe mental illness that can (but not always) pose restrictions to engagement in a range of vocational activities.³² As Harvey et al. write, 'the more protracted the episodes of illness, the shorter the periods of

²⁹ Frost et al., op. cit., p. 11.

³⁰ Waghorn and Lloyd, op. cit., p. 11.

³¹ Ibid., pp. 8-9.

³² It is, of course, important to note that the impacts are on an individual basis since psychosis represents a heterogeneous set of conditions and its experience is different from person to person.

remission and/or the greater the “residual symptomatology”, the more substantial the negative impact on social and occupational functioning.³³ People with severe mental illness face the specific issue of finding paid work with job designs that are suitable to their skills and flexible enough to accommodate the episodic nature of their condition.

Sector isolation and system failure

Perhaps the most fundamental indirect barrier to achieving better employment outcomes for people living with severe mental illness lies in sector isolation and its correlates: poor inter-sectoral collaboration, knowledge transfer, and a system that fails those it is intended to support. For example, mental health services continue to be isolated from vocational rehabilitation services and vice versa. This means clinicians can be unaware of developments in the field of psychiatric vocational rehabilitation, and vocational specialists can be unaware of the latest clinical treatments that might address symptoms they regard as employment limitations. When uncoordinated, ‘both treatment and vocational plans are at risk of mutual interference, which, at any time, can obstruct progress in both domains and negatively impact on mental health consumers, their families and carers’.³⁴

Sector isolation is further compounded when Psychiatric Disability Rehabilitation and Support Services (PDRSS) are put in the frame. As noted by Frost et al., the need for rehabilitation is often overlooked by mental health clinicians in the early stages of psychosis; as time lapses, so too does what can be achieved by rehabilitation in terms of recovery and self-determination in social and economic participation.³⁵

There is no doubt that effective partnerships between mental health, vocational rehabilitation, and specialist employment services would result in better employment outcomes. It is also important to remember that many consumers have complex needs around housing and health as well. (See the companion papers in this series on ‘Housing and Support’ and ‘Health Inequalities’ for more.) It is likely that those looking for work require other services alongside employment assistance. But when the majority of these services—and the sectors they belong to—operate in ‘silos’, there is little chance that consumers will be appropriately linked. Many miss out on services or drop out of the system entirely, meaning they don’t find work, or gain appropriate housing, or have their health needs met.³⁶

Navigational complexities in using employment (and other) services

This barrier is related to sector isolation and refers to the experiences of the job seeker. The main publicly-funded employment services available to people with disabilities are generalist Job Network providers funded by the Department of Education, Employment and Workplace

³³ Harvey C, Evert H, Herrman H, Pinzone T and Gureje O (2002) *Disability, Homelessness and Social Relationships Among People Living with Psychosis in Australia*, National Survey of Mental Health and Wellbeing Bulletin 5, Canberra: Mental Health Branch, Commonwealth Department of Health and Ageing, p. 3.

³⁴ Waghorn and Lloyd, op. cit., p. 5.

³⁵ Frost et al. op. cit., p. 15.

³⁶ Mental Health Council of Australia, op. cit., p. 33.

Relations (DEEWR), and a range of non-government and private organisations specialising in disability employment services (i.e. DEN) funded by the Department of Family and Community Services. A small number of DEN providers specialise in assisting people with psychiatric disabilities (e.g. Groundwork (EACH), Prahran Mission, Pathways and Reachout).³⁷ Other options for people with disabilities are the publicly-funded vocational rehabilitation services (VRS). These services are provided by CRS Australia (funded by DEEWR) and others. The Personal Support Program (PSP) is also available to people with severe mental illness. The PSP provides intensive support to those experiencing challenging circumstances in their lives and barriers to workforce participation (e.g. homelessness, problematic substance use, mental illness, and family violence). To use any of these services, job seekers must first be 'streamed' by undertaking a 'Job Capacity Assessment' or JCA. The majority of JCAs are done through Centrelink, the publicly-funded income support agency.

Nearly all services that may be used by job seekers with severe mental illness are federally funded. Whilst few (if any) employment and income support services are funded by state/territory governments, this is not the case for mental health services and PDRSS. These are almost wholly funded through state/territory jurisdictions. Yet, between these two major service types—mental health and employment—are very few embedded linkages. There is instead a 'constellation' of shared federal and state government funding arrangements to administer various programs available to the consumer, not to mention split departmental responsibilities across federal/state levels. What this amounts to are significant navigational complexities for unemployed people with psychiatric disabilities. As Waghorn et al. write:

*[A] job seeker with severe mental illness may need to access and coordinate three or more sectors across two levels of Government. For instance, a job seeker may be simultaneously engaged with a State or Territory mental health service, the Federal income support agency, and a private disability employment service contracted to the Federal government.*³⁸

If housing and health needs are thrown into the mix, the consumer experience becomes even more complicating, confusing and frustrating. Waghorn and Lloyd note that unless someone steps up to coordinate everything, the task is left to the person least able to perform this role: namely, the consumer. They add that 'inadvertent exclusion' to employment is the most likely outcome of these navigational complexities.

Factors related to job capacity assessment

The JCA can paradoxically act as a barrier to positive employment outcomes. As mentioned, job seekers with psychiatric disabilities must undertake a JCA by Centrelink to determine eligibility into publicly-funded employment service streams. On one hand, assessors can underestimate the assistance needs of job seekers during times of relative symptom stability. As Frost et al. note, the assessment is not sensitive to a course pattern of illness approach but

³⁷ Ilesley B (2007) 'Employment of people with a mental illness: Issues and implications for the Psychiatric Disability Rehabilitation and Support Services sector' in *New Paradigm*, June, p. 18.

³⁸ Waghorn G, Collister L, Killackey E and Sherring J (2007), 'Challenges to implementing evidence-based supported employment in Australia', in *Journal of Vocational Rehabilitation*, 27, p. 31.

rather takes a 'cross-sectional' view of the presenting client.³⁹ On the other hand, assessors can overlook the real difficulties experienced by some clients in undertaking the actual assessment. Either scenario has implications for the level of support received and the eventual employment outcomes for the client. Clients can find themselves in receipt of support that does not match needs, putting them in constant danger of infringing job search requirements (and having to carry associated financial penalties). Being incorrectly 'streamed' also means that a successful job seeker may not receive appropriate ongoing support to keep their employment.⁴⁰

This skills deficiency of employment services assessors in working with people with serious mental illness is documented in the Commonwealth Ombudsman's *Annual Report 2006-2007*.⁴¹ The report identifies a concern that the number of people with mental illness who 'fall through the cracks' is a result of the current service model. These are people who wish to obtain employment but who find themselves inappropriately 'streamed' into employment services through the process of the JCA.

Capped programs

The current employment services system places limits on the number of clients accessing programs such as PSP, DEN and VRS. Capping produces long waiting lists and discontinuity in service provision—both of which are counterintuitive to the rapid job searching approach of early intervention. Capping can also mean unsuitable referrals to Job Network, a generalist service for job seekers who do not require specialist support for finding work. People with severe mental illness referred to Job Network can miss out on critical supports they may need. And, as mentioned previously, being placed in Job Network can expose consumers to activity requirements that are particularly challenging given the episodic nature of their condition. Even if Job Network services reveal themselves to be clearly inappropriate for clients with severe mental illness, there is no easy way to be transferred to other programs, or to access other programs, due to capped places and administrative (bureaucratic) barriers.⁴²

A disincentive system

The 'Welfare to Work' changes to income support introduced in 2006 have heightened anxieties around potential loss of income supports. The changes included new measures around payment arrangements and activity regimes for identified target groups including people with disabilities. Clients can now be referred to Centrelink to undertake a JCA for their Disability Support Pension (DSP) claims, and having an assessment immediately starts a review of their entitlements. If assessors find that work capacity exceeds the hours allowed under the pension or that the client's impairment is less than a certain number of 'points', then their DPS can be cancelled. Whilst clients may be entitled to other types of payments (such as Newstart)

³⁹ Frost et al., op. cit., p. 6.

⁴⁰ Mental Health Council of Australia, op. cit., pp. 28-9.

⁴¹ Commonwealth Ombudsman (2007) *Annual Report 2006-2007*, Canberra: Commonwealth of Australia, as cited in Mental Health Council of Australia, op. cit., p. 28.

⁴² Mental Health Council of Australia, op. cit., p. 64.

it is the fear of losing existing payments that is paramount.⁴³ (Newstart provides less generous entitlements than the DPS.)

In this climate of fear, consumers are also concerned about their chances of re-establishing income and welfare supports should they need to in the future. Job seekers are sometimes reluctant to demonstrate their willingness to work for fear of losing their DSP and not being able to regain it and associated benefits (e.g. Health Care Card) should they get and then subsequently lose a job through relapse.⁴⁴ In this sense, 'Welfare to Work' has functioned as a disincentive scheme.⁴⁵

Stigma and disclosure issues

Stigma exists in the service system, the workplace and wider community and acts as a major barrier to employment outcomes for people with severe mental illness. According to Waghorn and Lloyd, mental health professionals can have low expectations of the vocational capacities of their patients, mirroring wider societal beliefs that those with psychiatric disabilities are unfit for work.⁴⁶ Frost et al. concur with this finding, citing several studies that show that very few clients are asked about their vocational interests by their mental health workers.⁴⁷ This leads to bias towards prevocational programs and reluctance to engage with vocational rehabilitation services. Within the vocational rehabilitation sector, professionals without training in the specialist field of psychiatric vocational rehabilitation may favour the selection of consumers with more familiar/stable mental illness. The end result is that those with the most severe mental illness are even more marginalised by the services that are there to help them.⁴⁸

None of this is helped by the fact that the pool of employers available to recruit people with severe mental illness is limited due to misconceptions about mental illness. Whilst no Australian studies exist, evidence in the UK shows that a significant proportion of senior managers do not have workplace mental health policies in place. Of those who do, only 16% believe they are well understood and even less (14%) feel they are effective. This same study revealed that a significant number of employers believe that employees with mental illness are a significant risk to the organisation (e.g. loss of productivity due to periods of leave). Some believe that leave periods of more than a few weeks means that recovery is not possible, and that paying out employees rather than supporting their return to work would be a preferred option.⁴⁹

Disclosure is a major issue for people living with severe mental illness and is felt a number of levels. At the start of the job seeking process are the employment services. Through the JCA, the weight of disclosure is placed on the individual. A person may choose not to disclose their

⁴³ Ibid., p. 28.

⁴⁴ Ibid., p. 31.

⁴⁵ Ilsley, op. cit., p. 19. In July 2008, the Federal Government decided to protect the incomes DSP job seekers. From September 2008, the assessment of pension eligibility will be separated from the assessment of employment assistance needs and people on DSP will be able to have employment assistance needs assessed without fear of losing income in the process.

⁴⁶ Waghorn and Lloyd, op. cit., pp. 25-26.

⁴⁷ Frost et al., op. cit., p. 14.

⁴⁸ Ibid., p. 7.

⁴⁹ Future Foundation (2006) *Mental Health the Last Workplace Taboo: Independent Research into What British Business Thinks*, Wiltshire UK: Shaw Trust as cited in Mental Health Council of Australia, op. cit., p. 25 and p. 27.

illness to Centrelink and/or employment service providers due to fear of discrimination and the impact on employment prospects if they do. This can have a bearing on the way a job seeker is 'streamed' into employment services. Along with the limitations of the current JCA model to appropriately assess people with mental illness, the disclosure issue is another factor that contributes to clients being inappropriately matched to supports.⁵⁰

Within the workplace, disclosure remains problematic due to fear of discrimination or embarrassment about mental illness. A recent SANE Australia survey of 284 people with mental illness found that over half (57%) of those who had ever worked had disclosed their condition to their employers. Of those who had disclosed, 67% said that it had been helpful in fostering a more understanding work environment for them and alleviating stress at work.⁵¹

Lack of longer-term supports for job retention

Appropriate supports are the key not only to attaining employment but retaining it as well. Many people with severe mental illness require longer-term supports to keep their job once employment has been achieved. The current employment service system does not provide for such supports. Resource and time limitations built into most existing contracts with publicly-funded providers, mean they are not in a position to develop and sustain truly effective relationships with clients to ensure successful job retention.⁵²

A comparison can be made with the Structured Training and Employment Projects (STEP) for Indigenous job seekers that attempt to provide employment support over a longer span of the pre-employment, placement and post-placement phases. According to MHCA, there may be benefits in providing similar programs to people with severe mental illness, given the overall cost burden borne by the government and community through high levels of unemployment and workforce non-participation in this group.⁵³

Housing insecurity

It is difficult to overlook housing insecurity as a major barrier to employment outcomes for people living with severe mental illness. The Low Prevalence Study Group research found that 42% of participants were living in tenuous forms of accommodation (e.g. institutional settings, hostels, boarding houses, rented rooms, crisis accommodation, and shelters) or were homeless at the time of the interviews.⁵⁴ Unmet accommodation needs do little to engender the sense of stability required to facilitate employment (and indeed, other vocational) directions. It is highly likely that a large number of people with a psychiatric disability, who are capable of greater economic participation, are restricted by housing insecurity brought about by marginal forms of accommodation.⁵⁵

⁵⁰ Mental Health Council of Australia, op. cit., pp. 28-9.

⁵¹ SANE Australia (2006) *Research Bulletin: Employment and Mental Illness*, South Melbourne: SANE Australia.

⁵² MHCA notes that where people with severe mental illness receive employment assistance through a DEN provider the outcomes have been shown to be positive. The problem, however, is in the limited DEN places available because of capping. See Mental Health Council of Australia, op. cit., p. 56.

⁵³ Mental Health Council of Australia, op. cit., p. 34.

⁵⁴ Jablensky et al. op. cit., p. 33.

⁵⁵ Frost et al. op. cit., p. 22.

Barriers to restoring educational trajectories

Given the strong link between educational attainment and employment outcomes, it is important to address disrupted educational trajectories as part of an effective vocational rehabilitation approach for people living with severe mental illness. There are, however, a number of barriers that present to this group making it difficult to undertake education activities as part of their rehabilitation plan. In discussing these barriers, it is worthwhile to keep in mind a 'life stages approach' and three broad cohorts identified above: younger people who are 'close' to their original vocational path, older people whose illness interrupted established careers, and older people who have never established a vocational direction in their lives.

Limitations through symptoms

The symptoms of severe mental illness can impact on thinking, behaviour, perception, judgment and affect, and there may be certain side effects from medications as well. The symptom manifestations of severe mental illness present unique challenges around the actual task of studying and learning, getting to every class, navigating one's way across campus, and getting through classes without breaks. Whilst on-campus learning support services are available to students with disabilities, educational institutions often lack appropriately trained teachers and support personnel to meet the specific learning needs of people with psychiatric disabilities.⁵⁶

Due to the characteristics of their symptoms, people with severe mental illness can also experience barriers with regard to a range of administrative processes characteristic of educational institutions. These include the sometimes complex task of enrolment and selecting subjects, the lack of recognition for prior learning, and academic records that show 'fail' rather than 'incomplete' due to relapse.⁵⁷

Literacy and numeracy issues

For those who became unwell during their secondary school years and/or have a history of institutionalisation, there may be added literacy (including computer) and numeracy issues that act as further barriers to pursuing education options.⁵⁸

Costs of study

Study can be expensive and people living with severe mental illness can find the cost of pursuing education activities prohibitive given their lower socio-economic status.⁵⁹ There are costs associated with fees, and whilst HECS can be deferred for people with psychiatric disabilities undertaking university level studies, the debt still has to be paid in the long run. This

⁵⁶ Pathways to Opportunities Program op. cit., pp. 44-7.

⁵⁷ Ibid., pp. 49-52.

⁵⁸ Ibid., p. 62.

⁵⁹ Ibid., op. cit., 36-41.

may seem daunting enough for some to discount education as an option. There are also a host of non-tuition related costs to consider involving transport, the purchase of computers, resources and materials, etc. Some people with psychiatric disabilities also have fears about how their enrolment might impact on their entitlements to income support.

Sector isolation and system failure

There is poor (almost non-existent) collaboration between vocational education and training providers, the mental health sector, and disability employment services to assist people with psychiatric disabilities in restoring disrupted education trajectories. Partnerships are ad hoc rather than part of an integrated system. As noted in the discussion paper for the *National Mental Health and Disability Employment Strategy*:

In the same way that people with disability and/or mental illness are under represented in employment, so too are they under represented in vocational, education and training systems. This situation is exacerbated by poor links between state-administered school and post-school programs and Commonwealth-administered disability employment services.⁶⁰

Stigma

People with psychiatric disabilities report being worried that their condition will be obvious to teaching staff and other students and that this will lead to negative treatment.⁶¹ Fear of discrimination is sometimes enough to deter some from considering study as a viable option in life. For those who are older and thinking about returning to study, there may be additional reservations about being in a mainstream classroom situation with students much younger than themselves.

Housing insecurity

As with employment, unmet accommodation needs mean that people living with severe mental illness are often without a base from which to pursue education options. It is highly likely that a large number of people with a psychiatric disability, who wish to return to study as part of their rehabilitation, are restricted by housing insecurity.

⁶⁰ Commonwealth of Australia (2008) *National Mental Health and Disability Employment Strategy*, op. cit., p. 11.

⁶¹ For this discussion see Pathways to Opportunities Program, op. cit., p. 26 and p. 31.

Achieving employment outcomes: what works?

All people have the right to opportunities for social and economic participation, however, the significant barriers to achieving and retaining paid work amongst those with severe mental illness require evidence-based strategies to put things right—and for this to be done as early as possible in the life course of the illness.

At the heart of such interventions is an approach that integrates specialist employment services with mental health services. This approach, known as specialised supported employment, draws heavily on the model of Individual Placement and Support (IPS) developed by Robert Drake and Deborah Becker at the New Hampshire-Dartmouth Psychiatric Research Centre in 1993. IPS-based programs have been extensively evaluated and typically result in employment outcomes for 40-60% of participants—up to three times greater than programs without integration.⁶²

According to Waghorn and Lloyd, in addition to the overall outcomes achieved by IPS-based programs there is strong evidence of effectiveness for most of its core principles.⁶³ These are:

1. Eligibility for employment services based on consumer choice, not job readiness.
2. Integration of disability employment services with mental health care.
3. The goal of competitive or open employment.
4. Rapid commencement of job searching activities.
5. Job placements based on consumer preferences, strengths, experience, and interests.
6. Continuing support to retain employment.
7. Income support and benefits counselling.

There is emerging evidence of effectiveness for the following 'ingredients' from other models such as transitional employment, vocational rehabilitation specialising in psychiatric disability, and non-specialised vocational rehabilitation. Ingredient 11 reflects an emerging candidate although there is not yet clear evidence to support this strategy for employment outcomes (but there is for mental health promotion).

⁶² Bond G (2004), 'Supported employment: Evidence for an evidence-based practice' in *Psychiatric Rehabilitation Journal*, 22:4, pp. 345-59. The use of the term 'specialised supported employment' is used in the IPS sense. It is not to be confused with the use of a similar term in Australia, 'supported employment', which refers to group-based sheltered work provided by business services through modified (i.e. not fully open or competitive) settings. See Waghorn and Lloyd, op. cit., p. 5.

⁶³ Waghorn and Lloyd, pp. 30-1.

8. Continuous availability of intensive onsite workplace support.
9. Multidisciplinary teams to coordinate treatment and vocational interventions.
10. Alliance between staff and consumers in rehabilitation.
11. Strategies to counter workplace stigma.

Waghorn and Lloyd argue for an ‘ingredients’ approach to the principles of evidence-based practice to avoid a ‘model-versus-model’ scenario. In Australia, ingredients that are not routinely used in the delivery of employment and vocational services for people with psychiatric disabilities (and would thereby indicate service gaps) are ‘integration of disability employment services with mental health care’, ‘intensive onsite workplace support’, ‘multidisciplinary teams to coordinate treatment and vocational interventions’, and ‘strategies to counter workplace stigma’.

Whilst avoiding a ‘model-versus-model’ scenario is recommended, it is also important to acknowledge that some consumers may not be in a position (or may not wish) to consider competitive or open employment. For them, a stigma-free work environment—such as those provided through sheltered workshops, transitional employment/clubhouse models, and social firms—may be desired to rebuild work and social skills and confidence.⁶⁴ Opportunities should be made available so that people with severe mental illness have available to them a range of different evidence-based employment programs, from IPS to more sheltered approaches.

Achieving education outcomes: what works?

Vocational rehabilitation that assists people in restoring illness-disrupted educational trajectories is also a part of a good practice approach to employment for people with severe mental illness, given the strong link between onset of illness and disruption to education/career development. Creating education opportunities can lead directly to improved opportunities for employment. Conversely, not addressing educational disruption ‘can flatten potential career trajectories, constraining people to entry level employment or to lower paid, less skilled, less satisfying, and more labour intensive jobs.’⁶⁵

⁶⁴ Ibid., pp. 30-3. Further discussion on models of employment assistance can be found in a recent DEEWR review of employment assistance for people with mental illness. This review notes the variety of terms and concepts used to describe and evaluate different models for achieving employment outcomes. Many programs have been implemented internationally and nationally, and different names can sometimes refer to essentially the same approach. The review makes an attempt to place a number of models into six basic categories based on goals (e.g. open employment, sheltered employment, preparation for employment, self-employment), methods (e.g. IPS, clubhouses, ‘train and place’, etc.) and characteristics (i.e. services and sectors involved). See Commonwealth of Australia (2008) *Employment Assistance for People with Mental Illness*, op. cit., pp. 28-31.

⁶⁵ Ibid., p. 33.

Approaches include the supported education programs developed by the Centre for Psychiatric Rehabilitation, Boston University, in the early 1980s. According to Frost et al, the aim of such programs is 'to provide access to university or higher learning opportunities through a normal, non-stigmatising environment.'⁶⁶ There is no particular model that ties together supported education efforts; however, programs typically include the following elements:

- Academic and functional assessment.
- Assistance with career choices.
- Skills teaching (e.g. study skills, stress and time management).
- Utilisation of equipment (e.g. computers).
- Assistance in enrolment and access to campus-based services.

Supported education programs have been investigated extensively. Findings suggest that supported education is overall successful as a pathway to better employment outcomes.⁶⁷ Even though the attendance rates of those with psychiatric disabilities tend to ebb and flow over time (commensurate with the episodic nature of their condition) studies show that those who persevere with programs achieve pass rates consistent with the mainstream student population.⁶⁸ Frost et al. also cite a review that demonstrates strong links between supported education programs and improved quality of life and educational/occupational status.⁶⁹

There is emerging evidence too, that the 'zero exclusion' principle of the model of IPS used in evidence-based specialised supported employment programs can be successfully applied to supported education models. This involves not excluding anyone who says they would like to study and then providing them with the supports to do so successfully. As noted above, research shows that the principle of zero exclusion in specialised supported employment approaches results in higher rates of employment and satisfaction amongst people with psychiatric disabilities.

⁶⁶ Frost et al, op. cit., p. 19.

⁶⁷ Waghorn and Lloyd, op. cit., p. 37.

⁶⁸ Frost et al, op. cit., p. 19.

⁶⁹ Ibid., p. 19.

Good practice examples

ORYGEN Youth Health IPS Initiative

The Early Psychosis Prevention and Intervention Centre (EPPIC) at ORYGEN is a program that provides mental health treatment and care for young people with first episode psychosis.⁷⁰ The IPS initiative at ORYGEN saw the appointment of a full-time employment specialist to one of the two EPPIC teams. Clients receive assistance for 18 months followed by referral to adult mental health services for ongoing care. The employment specialist works with young job seekers independently of the existing employment system and external agencies.

ORYGEN conducted a randomised controlled trial of its IPS initiative over a six-month period involving 41 young people with first episode psychosis randomly allocated to the IPS and control groups.⁷¹ Twenty people received assistance through IPS along with standard EPPIC treatment and 21 people received only the EPPIC treatment. The trial found that overall the IPS group had better employment outcomes than the control group.

Mental Illness Fellowship Victoria and St Vincent's Hospital Supported Employment Initiative

The Mental Illness Fellowship Victoria (MIFV) is a consumer organisation that has a contract with DEEWR to deliver disability employment services to inner-city residents with psychiatric disabilities.⁷² MIFV established an evidence-based site at St Vincent's Hospital in 2006. This initiative saw the co-location of a full-time employment specialist with a capacity for 25 job seekers at the community-based mental health team at the hospital. The employment specialist is supervised through regular onsite visits by the MIFV Employment Coordinator. The two agencies have a formal Memorandum of Understanding and good cooperation has been achieved between the clinical team and the employment specialist.

Early indications are that the employment outcomes of consumers are exceeding expectations.⁷³

Mental Illness Fellowship Victoria Training and Education Program

MIFV also runs accredited training and education courses.⁷⁴ These courses have been developed to meet the needs of people with severe mental illness. The 'Return to Learning and Self-Development Course' (Certificate in General Education for Adults) aims to ease students back into a learning environment, improve educational standards and acquire skills instrumental for future employment and achieving life's goals. The course is for people with severe mental illness who have aspirations for further study or employment, need career

⁷⁰ For this discussion, see Waghorn and Lloyd, op. cit.

⁷¹ Killackey E (2007) 'Vocational intervention in first episode psychosis: A randomised controlled trial' Presentation to the 17th Annual TheMHS Conference as cited in Mental Health Council of Australia, op. cit., p. 41.

⁷² For this discussion, see Waghorn and Lloyd, op. cit.

⁷³ Mental Health Council of Australia, op. cit., p. 41. MIFV subsequently established another site in Shepparton in the Goulburn Valley in partnership with DEN provider Worktrainers and the local state funded mental health service. This site also saw the collocation of a full-time employment specialist at the mental health service.

⁷⁴ For this discussion, see Mental Health Council of Australia, op. cit., p. 51.

planning and guidance, or have support workers able to engage with MIFV to support them during the course. Students who do not have support workers are not excluded from enrolment.

MIFV hope to integrate their employment and education programs to a greater degree to create direct pathways to employment for people nearing completion of the course.

Bendigo Bank Disability Employment Program

Business and corporations in the private sector can play a key leadership role in changing community perceptions of people with mental illness through developing and implementing good practice programs that employ people with disabilities and contribute to improved workplace diversity. As noted in the discussion paper produced for the *National Mental Health and Disability Employment Strategy*, a comprehensive approach to creating supportive environments led by 'disability confident employers' will enable the attitudinal changes required for the recruitment and retention of people with mental illness in workplaces across Australia.⁷⁵

In 2007, Bendigo Bank signed a Memorandum of Understanding with Disability Works Australia (DWA) to improve employment outcomes for people with a physical, intellectual or mental health disability.⁷⁶ Whilst Bendigo Bank does not monitor the numbers of people with disabilities coming through this program (it is, after all, up to the employees to disclose or not) there is an expectation that any workplace modifications required will be discussed with relevant managers/supervisors and responded to appropriately.

Good business outcomes have resulted from the new program. According to Bendigo Bank, there has been an overall increase in confidence with recruitment and a reduction in staff turnover. The main outcome reported is an attitudinal shift enabled by the program, with an expansion of people's minds to different possibilities.

⁷⁵ Commonwealth of Australia (2008) *National Mental Health and Disability Employment Strategy*, op. cit., p. 8.

⁷⁶ For this discussion, see Mental Health Council of Australia, op. cit., p. 54.