The Australian Psychological Society Ltd

Inquiry into mental health and education and workforce participation

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Contents

Executive summary of strategies to increase participation in education and employment 3

About the APS 4

Services provided by psychologists to Australians with mental illness 4

Introduction 5

Strategies and interventions to overcoming barriers to participation in education and employment 7

Key general recommendations to overcoming barriers to education and employment 8

Strategies that can be maintained or implemented in the short-term to address barriers to education and employment 8

Strategies that can be developed and implemented in the mid-to-longer-term to addressbarriers to education and employment 9

Support the mental health of people participating in education and vocational training by: 10

Support the mental health of people entering, in, or returning to the workforce by: 14

Conclusion 15

References 16

Executive summary of strategies to increase participation in education and employment

Key general recommendations to overcoming barriers to education and employment

1. Strategies and interventions must be evidence based and cost effective and have accountability mechanisms incorporated into funded programs.
2. High prevalence (e.g. mood and anxiety disorders) AND low prevalence (e.g. schizophrenia and other psychotic disorders) BOTH warrant attention and resources.
3. Fund large scale studies to evaluate the effectiveness of interventions to improve education and workforce participation.

Strategies that can be maintained or implemented in the short-term to address barriers to education and employment

Ensure access to treatment and support services by:

1. Continuation of the Better Access to Psychiatrists, Psychologists and General Practitioners Mental Health program.
2. Funding the implementation of Individual Placement and Support (IPS) model of supported employment.

Strategies that can be developed and implemented in the mid-to-longer-term in order to address barriers to education and employment

Address stigma by:

1. Improving mental health awareness and “literacy”.
2. Ensure explicit coverage for people with mental illness in all current discrimination Acts.

Support the mental health of people participating in education and workforce training by:

1. Funding/employing qualified staff (e.g. psychologists) in schools and education and training institutions to assess and treat mental disorders in young people.
2. Improving mental health literacy in schools.
3. Utilising evidence based interventions in schools e.g. interventions for ASD and supported education.
4. Ensure consistency in support for students between and within the states, territories, and education systems.

Support the mental health of people entering, in, or returning to the workforce by:

1. Ensuring access to treatment when required.
2. Funding supported employment initiatives.
3. Providing incentives for the development and maintenance of psychologically healthy workplaces.

About the APS

The Australian Psychological Society (APS) welcomes the opportunity to provide feedback to the House of Representatives Inquiry into Mental Health and Workforce Participation (hereafter referred to as "the Inquiry").

The Australian Psychological Society (APS) is the peak national body for the profession of psychology, with over 19,500 members, representing nearly 70% of registered psychologists. As the representative body for psychologists, the APS has access to a vast pool of psychological expertise from both academic and professional service delivery perspectives. The APS has responsibility for setting professional practice standards, providing ongoing professional development and accrediting university psychology training programs across Australia. It is represented on a number of advisory groups involved in the planning, implementation and ongoing monitoring of Government policy initiatives.

Constant communication with its members, plus access to high level psychological expertise and detailed involvement in Government initiatives, enables the APS to significantly influence the psychology workforce to ensure best practice in health service delivery.

The APS has a proud history of working in collaboration with Australian Government departments and other organisations in the successful delivery of policies and programs aimed at improving the health, education and employment outcomes of Australians.

Services provided by psychologists to Australians with mental illness

Psychology is a diverse profession. The APS has nine specialist professional colleges for its members. They include:

- Clinical neuropsychology
- Clinical psychology
- Community psychology
- Counselling psychology
- Educational and developmental psychology
- Forensic psychology
- Health psychology
- Organisational psychology
- Sports and exercise psychology

Psychologists in numerous roles and settings provide a comprehensive range of services to Australians faced with barriers to education and employment. They include, but are not limited to:

- Diagnosis and treatment of psychological, behavioural and developmental disorders such as depression, anxiety, Autism Spectrum Disorders (clinical psychology, counselling psychology, neuropsychology, educational and developmental psychology);

- Diagnosis, treatment and improving the management of comorbid physical and mental health problems (health psychology);
- Formal assessment by a clinical neuropsychologist as part of a comprehensive cognitive assessment, including diagnosis, evaluation of functional capacity and identification of potential for improvement and supports to facilitate and develop opportunities for ongoing involvement and attainment of educational and employment goals (clinical neuropsychologist);
- Working with organisations, teams and individual employees to improve their motivation, effectiveness and productivity (organisational psychologists), and
- Advocating for policy changes on behalf of people with mental illness and developing strategies that utilise the resources of communities to help overcome barriers to education, training and employment (community psychology and counselling psychology).

The majority of this submission will focus on fundamental principles and major strategies to support people living with mental illness to participate in education, training and employment.

Introduction

It is well established that mental illness and physical and or mental comorbidities (Braden, Zhang, Zimmerman, & Sullivan, 2008) are common and exist across the lifespan. Not only is the nature of mental illness complex in itself, psychiatric disability is often part of a complex range of social, emotional and financial problems (McAlpine & Warner, 2001).

As noted by the Committee, mental disorders can and do affect education and employment opportunities in many ways. In addition to the emotional and health consequences, mental illness causes enormous financial costs to the community (Langlieb & Kahn, 2005). Thus it is in the whole community's interests to help improve treatment, educational and employment outcomes for people with mental illness.

Like physical conditions, mental illness effects people to varying degrees, depending on, for example, prior levels of functioning, social supports, and not least of all the nature of the illness. Symptoms and disorders might range from being relatively mild with a cyclical or brief duration, to those that are severe, chronic and persistent and completely debilitating. Examples of the range of psychological disorders that affect educational and employment participation include:

- Depression, often referred to as "the common cold of psychiatry" has, amongst other consequences, impaired social, educational, and job performance. Longitudinal studies show that unemployed people with depression are far less likely to become employed than those without depression (Simon et al., 2000). Furthermore, a recent American, population based study found that rates of disability and unemployment increased substantially depending on the severity of the depression (Birnbaum et al., 2010).
- Anxiety disorders – include a range of diagnoses, particularly Post-traumatic Stress Disorder, Social Phobia, Obsessive Compulsive Disorder and Panic Disorder with or without

Agoraphobia. For those in employment, this can often lead to decreased work productivity rather than absenteeism from work (Greenberg et al., 1999). In Australia, anxiety disorders have been associated with: reduced labour force participation, degraded employment trajectories and impaired work performance compared to people without disabilities or long-term health conditions (Waghorn, Chant, White, & Whiteford, 2005). Additionally, anxiety disorders can impair career progression and lead to the shortening of careers (Waghorn et al., 2005).

- Autism spectrum disorders (ASD) – typically diagnosed in early childhood and with a long duration had varying degrees of severity that impacts on learning, development and social interaction. ASD have an estimated prevalence of between 24 to 47 per 10,000 for Autism; 12.7 to 15.3 per 10,000 for Asperger's; and 37 to 63 per 10,000 overall, and have been estimated (in 2007) to costs the Australian community between $4.5 billion and $7.2 billion per year (Synergies Economic Consulting, 2007).

- Psychotic disorders and other low prevalence severe mental disorders such as Bipolar disorder can and do have severe impacts on social and occupational functioning, especially when undetected and untreated. However, when symptoms are well managed it is possible to reach educational and employment related goals. For example, one recent study that examined employment related outcomes for people diagnosed with bi-polar disorder found that about 50% were working and that better outcomes were related to higher education, less severe symptoms and shorter duration of illness (Elinson, Houck, & Pincus, 2007). An earlier Australian study reported that of people with psychosis living in households aged 15-64 years that had completed post secondary school studies, 24% managed to complete their studies following onset of the symptoms (Waghorn, Still, Chant, & Whiteford, 2004).
- Comorbidities - People with one or more mental disorders (with or without additional physical health related conditions) are more likely to experience difficulties and adverse outcomes related to completing secondary and tertiary education, attaining higher level degrees and subsequently attaining, maintaining, and/or re-integrating back into the workforce (Braden et al., 2008; Okoro, Strine, McGuire, Balluz, & Mokdad, 2007). In financial terms, the costs associated with psychological comorbidities is greater than with a single diagnosis (McAlpine & Warner, 2001; Roy-Byrne et al., 2000), and comorbid physical health conditions have been found to be negatively associated with employment status (Waghorn, Lloyd, Abraham, Silvester, & Chant, 2008).

While diagnostic labels can offer a shorthand way of summarising symptoms and *likely or probable* outcomes, it is critical to understand that diagnosis itself does not necessarily relate to the level of functional impairment (Anthony, 1994; Schultz, Rogers, & MacDonald-Wilson, 2011). For example, the relationship between education level and employment status in anxiety disorders (although not necessarily for psychosis) is relatively independent of disorder severity (Waghorn et al., 2004); and, people with anxiety disorders have been found to work in all occupational categories and industry groups similar to people without anxiety disorders (Waghorn et al., 2005).

To reiterate, mental illness can and does have many significant and adverse effects on educational and employment outcomes. *However*, diagnostic labels are not necessarily related

to the level of functional impairment a person experiences *Furthermore*, the majority of people with, or who have previously had a mental illness are indeed able to and do work (Morrow, Wasik, Cohen, & Perry, 2009). The APS also wants to stress that employment participation for people with mental illness is not about sheltered workshops but about meaningful, competitive employment options that can aid recovery, and foster self esteem. For those living with a mental illness, it is also well documented that most, not already in employment, do want to work (McAlpine & Warner, 2001). Gaining competitive employment is also a more realistic goal given that within the broader community there has also been a gradual shift in attitudes towards mental health (Hinshaw & Cicchetti, 2000). Furthermore, given that different psychological and or behavioural symptoms will have different functional impacts on people it is important to have a flexible range of economic/financial supports and psycho-social interventions available to assist people in a responsive manner (Morrow et al., 2009).

The APS would also like to commend the Inquiry for focusing on solutions to barriers to education and employment as there has already been much research on what barriers do prevent participation in education and employment. The APS submission recognises this and subsequently, comments will be made with regard to major categories of barriers that include:

1. Characteristics or nature of the mental disorder(s) – impacts of age of onset, course of the disorder, severity of the symptoms and their respective impacts on educational and employment functioning;
2. Personal characteristics – motivation to achieve educational and employment goals; personal resources and supports (including, for example, socioeconomic status). For example, there is a lot of evidence demonstrating that extended time out of the workforce can have long-term negative impacts, particularly with length of time out of the workforce linked to poor self-esteem, increases in mental health problems, and decreased rates of employment;
3. Access to treatments/interventions and supports; and,
4. Characteristics of the labour market, work itself, legislative context, and teacher, employer, or therapist attitudes (stigma). For example, there is evidence that some therapists and/or support workers are more likely to think that any form of employment is an unrealistic goal for people with mental illness, and thus discourage people with a mental illness from seeking work.

Strategies and interventions to overcoming barriers to participation in education and employment

Most barriers to workforce and education participation will not be overcome quickly. However there are initiatives and principles that the Government should maintain and follow to help remove these barriers. Key principles will be addressed before more specific strategies and initiatives are proposed and or recommended for the short and longer terms.

Key general recommendations to overcoming barriers to education and employment

1. Strategies and interventions must be evidence based and cost effective and have accountability mechanisms incorporated into funded programs.

   Strategies and interventions must demonstrate efficacy and be cost effective to have an impact, be sustainable and be socially and politically viable (Waghorn, Chant, Lloyd, & Harris, 2009). Where there is evidence of interventions or programs not working, no matter how appealing or "easy" they might appear, action must be taken. Importantly, steps need to be taken to address gaps that can develop between research and practice (Burns & Ysseldyke, 2009).

2. High prevalence (e.g. mood and anxiety disorders) AND low prevalence (e.g. schizophrenia and other psychotic disorders) BOTH warrant attention and resources.

   However, if an argument is to be made primarily on economic grounds, then high prevalence disorders should be prioritized. This is because they are more easily treated, with better outcomes, are less costly and affect a greater percentage of population than low prevalence disorders. This is further strengthened by the fact that people with some symptoms of mental disorders but who do not warrant a diagnosis also experience impaired performance and outcomes in education and employment (Angold, Costello, Farmer, Burns, & Erkanli, 1999).

3. Fund large scale studies to evaluate the effectiveness of interventions to improve education and workforce participation.

   The funding of research that is developing, implementing and evaluating large scale interventions are required to complement the relatively large number of small scale trials and interventions that have been published. For example, much of the research focusing on the interventions for ASD has focused on single-case study designs (Williams, Johnson, & Sukholdolsky, 2005).

Strategies that can be maintained or implemented in the short-term to address barriers to education and employment

Ensure access to treatment and support services by:

1. Continuing to fund the Better Access to Psychiatrists, Psychologists and General Practitioners Mental Health program.

The alleviation of psychological distress and mental disorders is related to improvements in educational and employment outcomes (Judd et al., 2000). Ensuring timely access to evidence-based treatment for both high and low prevalence disorders will address both access to treatment and the barriers inherently related to the nature of mental disorders (Krupa, 2007).

Facilitating access to psychological treatments for mental disorders that are efficacious and evidence-based represents excellent value for money. Independent evaluation of the Better Access to mental health care demonstrated significant benefits to consumers and significant cost-savings to Government (Pirkis, Harris, Hall, & Ftanou, 2011). The financial costs of the effects of mental disorders on education and employment are high but have been significantly impacted by the Better Access to mental health care Medicare items (Pirkis, et al. 2011). Ongoing funding of this scheme is of vital importance to investing in the mental health and future productivity of the workforce. For example, the fluctuating nature of some symptoms of mental illness - seen as a major barrier to employment and education (Atkinson, Bramley, & Schneider, 2009) – can be readily addressed through timely access to affordable, evidence-based psychological interventions. A specific example might be where a person who experiences a depressive episode while employed would be able to get a referral from their GP, receive Medicare rebates to see a psychologist while only taking a period of time off work (as paid or unpaid sick leave). As such, they would be able to access cognitive behavioral therapy and then return to their position as any person returning from a physical condition would do.

2. Funding the implementation of Individual Placement and Support (IPS) model of supported employment.

Typically used for low prevalence disorders (severe mental illness). There is high quality evidence from randomised controlled trials (T. Burns et al., 2007), systematic reviews (Crowther, Marshall, Bond, & Huxley, 2001) and meta-analyses (Twamley, Jeste, & Lehman, 2003) that IPS obtains better competitive employment outcomes for people with severe mental illness than alternative vocational programs regardless of background, demographic, clinical and employment characteristics (Becker, Whitley, Bailey, & Drake, 2007; Campbell, Bond, & Drake, 2011). Supported employment is also effective for people with co-morbid mental illnesses (Becker, Drake, & Naughton, 2005).

Australian trials for implementing this scheme (King et al., 2006; Waghorn, Collister, Killackey, & Sherring, 2007) however, have already highlighted some of the difficulties in implementing this (Killackey & Waghorn, 2008). For example, the Centrelink Job Capacity Assessment is in conflict with the “no exclusion criterion” of the IPS model that states that whoever expresses a desire to work should be eligible for assistance. Additionally, a job seeker’s circumstance might be complicated by them being simultaneously engaged with State or Territory mental health service, Federal income support agency and a private disability employment service contracted to the Federal Government. A fundamental ideological problem has also been identified in that the Federal Government employment system did not recognising educational outcomes as a high priority compared with entry-level employment outcomes (Waghorn et al., 2007). This undervaluing educational participation is short-sighted, especially when considering that employment outcomes are improved when higher education levels are achieved.

Strategies that can be developed and implemented in the mid-to-longer-term to address barriers to education and employment

Address stigma by:

1. Improving mental health awareness and “literacy”; and
2. Ensuring explicit coverage for people with mental illness in all current discrimination Acts (i.e. not to discriminate on basis of gender, religion, mental illness etc).

Stigma affects children and adults (Hinshaw, 2005) with mental illness more than it does people living only with a physical disability (Martinez, Piff, Mendoza-Denton, & Hinshaw, 2011). Stigma against mental illness has devastating consequences for individuals with mental illness and their families. Empirical findings and qualitative evidence indicate that stigma against mental illness remains rampant and constitutes a significant barrier to successful treatment, reducing key life opportunities, and predicting poor outcomes over and above the effects of mental illness alone (Stier & Hinshaw, 2007).

Stigmatising attitudes among service providers and administrators not only prevent access to existing supports and services, but also slow or prevent the planning and development of new services (Soydan, 2004). Additionally, stigmatising beliefs can negatively influence decisions about retaining or promoting an employee (McAlpine & Warner, 2001). It is clear that stigma affects people with mental illness in many ways and must be addressed as a barrier to education and employment.

Addressing stigma through improving generally community attitudes toward mental illness can only take place if there is the legislative foundation for fairness and equality. It is thus imperative that current discrimination Acts cover and are applied to protect people with mental illness. Community-based programs that challenge unhelpful beliefs about people with a mental illness’ capacity to work need to be developed and sustained – these could target both schools and workplaces. Increasing general mental health literacy in the population, through events such as National Psychology Week, and organisations such as Beyond Blue, can facilitate early detection of symptoms and facilitate help-seeking behaviour.

Support the mental health of people participating in education and vocational training by:

1. Funding/employing qualified staff (e.g. psychologists) in schools and education and training institutions to assess and treat mental disorders in young people.

Employing qualified staff, such as psychologists, in schools and other educational and training institutions to assess and treat mental disorders will increase the likelihood of preventing and or minimising the effects of mental illness in younger people. Psychologists make up a large proportion of qualified mental health professionals working in educational and training institutions. They have at least six years of training with detailed knowledge of factors relating to individual’s behaviour, learning and development. Psychologists are experts in the design, implementation, monitoring and adjustment of intervention programs that are individually tailored to the needs of the people with mental illness. They work in collaboration with parents, teachers and other professionals in educational settings in order to produce the best outcomes.

The increasing demand for supporting students at all levels of education with social, emotional and, in many cases, mental health disorders has been well established. The consequent need

for greater numbers of staff with expertise to meet these vital needs has become critical. It is not surprising then that many in the community have expressed concern about the need to make the best use of scarce resources. Expenditure in schools on programs like the school chaplaincy is one example of a poor use of funds. Chaplains, despite their skills in pastoral care, are not qualified to assess and treat mental illness. This, as such, has both ethical and legal ramifications. Employing unqualified or over qualified staff in educational settings is not an alternative and is unjustified on economic grounds. The risk of substituting less-paid services for better professional services for young people with mental disorders far outweighs any short term benefits.

The APS has made a detailed submission to the Government about the need for qualified staff, such as psychologists, to be employed in schools. A copy of this submission can be accessed from the APS website (http://www.psychology.org.au/Assets/Files/APS-Submission-School-Chaplains-July2010.pdf).

For those in need at schools, having increased access to psychologists would also remove a significant barrier to accessing timely psychological and behavioural assessments. Competent psychological assessments are critical to decreasing the chances of mental illnesses, or cognitive impairments being missed or mistakenly diagnosed (Bor & Dakin, 2006). Therefore, minimising the impact of psychiatric symptoms as early as possible decreases the student's chances of academic failure (Soydan, 2004). Furthermore, intervention by competent professionals also assists individuals with mental illness to prepare and develop various coping strategies that can lead to long term benefits. For example, young people can learn skills to manage symptoms of depression when in school that will later be of help when seeking and mainlining employment, developing social relationships and coping with stressors in work, family and other environments.

2. Improving mental health literacy in schools

Developing the mental health literacy of younger people in schools could help facilitate the provision of support before relatively minor problems develop into more serious problems requiring intervention from professionals. Mental health literacy incorporates promotion, prevention and early intervention. For example, in childhood, promoting effective social and emotional competencies such as self awareness and self management will assist children to develop skills in coping, as well as being able to seek help, when necessary. Good mental health in general will lead to better coping and adaptation to life's transitions and stressors from childhood through to adulthood. The promotion of good mental health in the early childhood years will reduce risk and promote resilience in ongoing development.

The Kidsmatter (www.kidsmatter.edu.au) initiative recognises the importance of early childhood settings and schools in providing an environment in which age-appropriate social and emotional skills can develop. It provides a framework which supports early childhood settings and schools in identifying programs and approaches which explicitly teach children these skills. This allows staff to work effectively with children and families to identify early signs of concern and to provide support and referral pathways as early as possible. In this way they can particularly

promote psychological wellbeing in children and young people and improve educational outcomes.

3. Utilising evidence based interventions in schools (e.g. interventions for depression and providing supported education).

Evidence based psychological interventions exist for children and adolescents with mental illnesses, including anxiety disorders, depression and ASD. The APS has recently completed a comprehensive literature review of the effectiveness of psychological interventions for a range of mental health disorders. This literature review is freely available from the APS website (http://www.psychology.org.au/Assets/Files/Evidence-Based-Psychological-Interventions.pdf).

Psychologists in schools are equipped with the skills and knowledge to effectively assess and treat behavioural and psychological problems. By way of illustrating the role that evidence-based psychological interventions and psychologists can play in supporting the mental health of students, the example of depression will be cited.

As mentioned in the Introduction, depression has profound implications for many children and families around Australia, and has significant social and financial costs associated with it. Cognitive Behavioural Therapy (CBT) is an evidence based intervention for depression in children and adolescents (Butler, Chapman, Forman, & Beck, 2006; David-Ferdon & Kaslow, 2008). Children and adolescents with depression often experience low or depressed mood, loss of enjoyment in activities, suicidal ideation, loss of motivation, irritability, poor concentration, sleep disturbances and social withdrawal. These symptoms frequently interfere with learning and the development of social networks. The consequences of these symptoms include disrupted or incomplete studies (which has additional implications for future education and employment opportunities), social isolation from peers, and poorer physical health related outcomes.

In completing comprehensive assessments, psychologists will include a functional assessment to identify the variables that contribute to the identified symptoms and behaviors. They will examine the motivations or functions of the behaviors and where possible manipulate these to test that apparent relationships between the variables and behaviours do exist. Assessments must integrate information from multiple sources including: teachers, parents, the child involved, and also from direct observation. The findings from the comprehensive assessment will form the basis on which the intervention is tailored to the child. Examples of strategies include: the development of more acceptable replacement behaviours, developing coping strategies to improve mood, express frustrations, and strengthen or build social supports, monitoring of problem behaviors and the use of new coping strategies.

The recent evaluation of the Better Access program revealed that although young people had lower rates in the use of psychological services than adults in absolute terms, the relative growth in uptake between 2007 and 2009 was considerably greater for young people under 15 years than for all other age groups and that treatments were effective (Pirkis et al., 2011). The results for children also reflect the success of the Better Access program for adults with mental illness.

Another example of mental health disorders that can impair participation in education and training for children and young people is ASD. Although specific symptoms differ significantly from those with depression, the impact on outcomes related to learning and education can often be more severe than those with depression. Researchers and practitioners alike stress that due to the heterogeneity of the population with ASD and their variation in developmental stage, no "one size fits all" intervention is likely to be appropriate. Furthermore, it is important to note that behavioural disturbances in ASD are usually just one symptom that impacts on the child and that full, tailored interventions are typically resource intensive and relatively costly. While the Helping Children With Autism (HCWA) package (2008–2012) aims to help meet some of the costs associated with interventions for ASD, it has been criticised for falling short of funding the minimum 15–25 hours of intervention per week that is typically recommended (Roberts et al., 2011).

In order to support psychologists working with children and families with ASD, the APS has developed a suite of resources and maintains a list of identified practitioners who have completed specific training in assessing and diagnosing ASD (http://www.psychology.org.au/practitioner/resources/autism/).

The onset of a severe mental illness, which often creates or leads to psychiatric disability, frequently occurs between the ages of 18-25. This is an age when people are making career choices, pursuing higher education or vocational training, and establishing social networks (Soydan, 2004). Supported education (similar to supported employment) is the provision of individualised, practical support and instruction to assist people with psychiatric disabilities to achieve their educational goals. Importantly, it has been found to be a cost-effective intervention (Morrison, Clift, & Stosz, 2010). For example, an evaluation of an intervention in England for people with depression, anxiety disorders, bi-polar disorder, schizophrenia (with or without co-morbid learning difficulties), ASD, head-injury or substance use disorders was effective in improving mental health, educational outcomes and reported cost savings to the NHS of 7,000 pounds per person, per year (Morrison et al., 2010). At the individual level, benefits were also accrued through addressing education disruption, the loss of higher educational potential, and by countering secondary impacts of mental illness (Waghorn et al., 2004).

4. Ensure consistency in support for students between and within the states, territories, and education systems.

Funding and practical support for students with mental illness and severe behavioural disorders needs to be consistent between States and Territories in Australia (Bor & Dakin, 2006). The foundation for this can be made by ensuring that consistent or equal recognition is given to young people with mental disorders as it is to children requiring assistance for physical or learning disabilities. This in turn will require that schools and vocational training institutions and their staff have timely access to qualified professionals like psychologists to provide the appropriate level of support required. Thus, for example, if a child with depression needs to move interstate with their family, they will not be at risk of losing the support(s) they need to continue to participate fully in education.

Support the mental health of people entering, in, or returning to the workforce by:

1. Ensuring access to treatment when required.
2. Funding supported employment initiatives.
3. Providing incentives for the development and maintenance of psychologically healthy workplaces.

A recent literature review has confirmed what intuition would suggest about stressful work environments – that is, that there are strong links between workplace stress and poor mental health and employment related outcomes (LaMontagne, Keegel, Louie, & Ostry, 2010). This recent review supports calls to establish and invest in the psychologically healthy workplaces (Shain, 2009) – a domain of expertise that organisational psychologists are well placed to develop. Individual workplace interventions need to be supported by broader, macro-level, occupational health and safety legislation that supports a "psychologically healthy workplaces" (in addition to the physically safe environment). A psychologically healthy workplace not only minimises the presence of negative stressors (e.g., prolonged demand, workplace bullying, sexual harassment), but should include mental health promoting factors that will only increase levels of support and resilience amongst employees. This will decrease the presence of stressors that can trigger episodes of depression or relapses of mental illness and or help people develop coping mechanisms to better manage stressors in a workplace.

Evidence from much recent work highlights the importance on productivity and the mental health of psychological processes like participation in decision making, a sense of being valued and respected, and a work culture that is participatory and committed to openly sharing power and information (Cotton & Hart, 2003).

Employee assistance programs (EAP's) are a popular form of external support provided to employees by employers (Kirk & Brown, 2003). However, due to difficulties associated with research methodologies there is a lack of evidence as to their effectiveness (Attridge, 2004; Colantonio, 1989; Kirk & Brown, 2003). (This is the main methodological challenge that has prevented large-scale evaluations of EAP's concerning the issue of client confidentiality.) One large American study on the effectiveness of EAPs compared absenteeism and other performance criteria for 303 EAP clients with those of 303 matched controls over a 5 yr time period (Macdonald, Wells, Lothian, & Shain, 2000). Interestingly, EAP clients had higher rates of sick days before, during and after treatment, compared to a matched control group (Macdonald et al, 2000). Additionally, rates of sick days had not significantly changed from before to after treatment among EAP clients. Counsellor reports revealed that the most common problem addressed by the EAP was personal mental health followed by family problems (both issues that might have affected productivity rather than absenteeism). Furthermore, an additional survey of EAP clients suggested that the majority of clients were satisfied with the overall quality of services, confidentiality, helpfulness of counsellors, and effectiveness of treatment.

While many EAP's have been criticised for focusing on the individual rather than the workplace (Morrison & Payne, 2003), this is not always fair, as EAP counselling services are not limited to supporting employees only with workplace related stressors. However, it is clear that interventions designed to decrease workplace stress and promote workplace health should

focus on both the individual and the organisation (LaMontagne et al., 2010; Noblet & LaMontagne, 2006). While issues related to economies of scale have been highlighted as representing a particular challenge for small business owners (Shain, Eakin, Suurvali, & Currie, 1998), others have found that the costs of supporting staff can be offset by decreased costs associated with lower staff turnover that result from “healthier” workplaces (Salkever, Shinogle, & Goldman, 2003).

Conclusion

There are many well documented barriers to people of all ages, with a mental illness participating in education and employment. The APS welcomes the acknowledgement from the Inquiry that there is no magical or quick solution to addressing the barriers. However, the APS strongly recommends that all interventions and strategies designed to increase participation in education and employment be based on solid evidence and inclusive of low and high prevalent disorders. In the short term, maintaining, if not increasing, funding for the Better Access to Psychiatrists, Psychologists and GP’s scheme represents an excellent “value for money” strategy to address barriers to education and employment. Longer-term strategies need to target the direct and indirect effects of stigma associated with mental illness.

The APS would welcome the opportunity to engage further with the Inquiry on these important issues.

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