Queensland Government Submission

to the

House of Representatives Standing Committee on Education and Employment

Inquiry into Mental Health and Workforce Participation

May 2011

Queensland Government

Contents

Introduction

In Queensland, as in other Australian jurisdictions, people experiencing mental illness continue to experience barriers to participation in education, training and employment. These barriers limit workforce participation by people experiencing mental illness and have ongoing implications for individual financial security and the economy more broadly. The Queensland Government regards this as an issue that goes beyond individual social justice, and has significant repercussions at a broader economic level.

The Queensland Government considers that opportunities for increased participation and retention in the workforce are crucial economic issues for the individual, for government and for Australia as a whole. It is also an issue of equity demanding national attention. Complex and poorly understood issues of systemic discrimination continue to limit opportunities for people with mental illness in the workplace, their personal financial security over the life course and the nation's economic progress and competitiveness.

It is widely recognised that employment is important to the mental health and well being of individuals. Employment is a key enabler of social and economic participation in society and can result in a wide range of benefits including reduced social isolation, reduced risk of homelessness and improved sense of worth and role within society. In addition, the Government recognises the importance of employment to economic growth and prosperity, which supports community wellbeing.

Queensland has been at the forefront of investing in and developing a comprehensive, recovery oriented mental health service system. The *Queensland Plan for Mental Health 2007 – 2017* (QPMH) outlines five priority areas for reform and development of mental health care — promotion, prevention and early intervention; improving and integrating the care system; participation in the community; co-ordinating care; and workforce, information, quality and safety. Improving cross sectoral collaboration and building effective partnerships are key principles underpinning the plan and significant activity is underway progressing these.

The QPMH represents the largest investment in mental health in Queensland's history and reflects the Government's commitment to delivering a better quality of life for people who experience mental illness, their families and carers. The *QPMH* draws on, and implements, the national directions set out in the *Fourth National Mental Health Plan* (Fourth Plan) and the Council of Australian Government's *National Action Plan on Mental Health 2006 – 2011*.

This submission will draw on the work underway towards implementing the Fourth Plan and the QPMH, which both have a focus on improved social and economic participation by people experiencing mental illness.

Queensland's leading work with respect to enhancing workforce participation for people with a severe mental illness — the Queensland Health Employment Specialist Initiative — is outlined in this submission and commended to the Inquiry as a model which may be adapted in a national context.

Queensland is also at the forefront of the delivery of innovative and effective labour market programs, particularly for those facing multiple barriers to employment or who are significantly disadvantaged in the labour market under the Skilling Queenslanders for Work (SQW) initiative. SQW encompasses a range of programs and assistance to ensure individual jobseekers access the support they need to address vocational

and non-vocational barriers to employment, and these are discussed in the submission to provide examples which can be adapted elsewhere.

Mental Illness in Queensland

Mental disorders are very common. In 2007, almost half the Queensland population aged 16–85 years reported experience of a mental disorder in their lifetime (47.4%) and 1 in 5 had experienced symptoms in the past 12 months (19.2%)[1].

Anxiety-related and depressive disorders are the most prevalent, affecting around 25 per cent of the population. More severe mental disorders affect almost 2.5 per cent of Queensland people with about half of this group having a psychotic disorder and the remainder experiencing major depression, severe anxiety and other disorders such as anorexia nervosa. It is estimated that mental illness is responsible for 24% of the burden of disability in Queensland[2].

People experiencing mental illness have high levels of unemployment and low workforce participation rates. It is estimated that around 54 per cent of people with a mental and behavioural condition participate in the workforce; and that around 25 per cent of people with psychotic disorders and around 52 per cent of people with anxiety disorders participate in the labour force. These levels contrast with the 80 per cent workforce participation rate of Australians aged 18 – 65 who do not have a disability[3].

Research shows that anxiety disorders, affective disorders, psychotic disorders and schizophrenia, in that order, have an increasingly negative impact on workforce participation throughout the working life. The impact of the disorders increase with severity of diagnostic category[4], and with when symptoms occur. People whose condition is normally mild and manageable can still experience periods of severe debilitation.

Support needed to access and maintain employment will vary amongst individuals, depending on personal background and goals as well as severity of mental illness.

Particular population groups such as women, people with disabilities, Indigenous peoples, people from culturally and linguistically diverse backgrounds and geographically isolated communities experience multiple disadvantages which act as further barriers to education, training and workforce participation. For example limited education, low skills, family violence, caring responsibilities for children, partners or parents, housing stress, poor health, disability, lack of access to services and substance misuse can contribute to and further entrench disadvantage and an individual's incapacity to secure and retain employment.

The prevalence of mental disorders is higher among people living in disadvantaged areas and decreases with increasing socio-economic advantage.

The complex interplay of culture, gender, geography, socio-economic background, life stage and age, interlaced with a range of mental illnesses (which vary in severity and duration) require individualised, supported interventions to develop sustainable pathways into and between education, training and employment.

[1] Queensland Health, 2010. The Health of Queenslanders. http://www.health.qld.gov.au/cho_report/2010/documents/2010choreport_ch4.pdf#page=32

[2] Ibid.

[3] The Australian Bureau of Statistics (ABS) Survey of Disability, Ageing and Carers, 1998 [3,28-31]

[4] Geoff Waghorn et al, 2010. *Earning and learning among Australian community residents with psychiatric disorders*

The Australian Government's 2011 – 2012 budget contains a number of measures designed to increase workforce participation by people with a mental illness. The point is made in the National Mental Health Reform budget statement that an estimated productivity loss of $5.9 billion per annum in Australia is attributable to mental illness[5]. While details of the resulting new employment programs are not yet clear, successful transition of people who are disadvantaged in the labour market requires significant investment in wrap-around case management. Individuals that have been outside of the labour market for significant portions of time mostly require intensive assistance that addresses a range of barriers to ensure they are able to achieve sustainable employment. Consideration must be given to closely linking employment, education and training support with mental health treatment, particularly for those experiencing more severe mental illness.

The productivity loss attributable to mental illness in Australia, while in part caused by non-participation in the workforce, is also a result of 'presenteeism' and absenteeism at work. Mental health within the workplace is of equal importance, and this submission discusses strategies for healthier workplaces.

It is the view of the Queensland Government that social inclusion is as important as economic inclusion. While the latter is often achieved through employment, social inclusion may also be realised through other activities including volunteering or caring for others, and these activities should be as valued as equally alongside paid employment. Many people experiencing mental illness add value to society intrinsically through the roles that they undertake rather than solely through an economic measure of workforce participation.

This submission addresses the three areas outlined within the terms of reference — barriers to participation in education, training and employment of people with mental illness; ways to enhance access to and participation in education, training and employment of people with mental illness through improved collaboration; and strategies to improve the capacity of individuals, families and community members, co-workers and employers to respond to the needs of people with mental illness.

The submission outlines the Queensland Government's existing commitment to improving outcomes for people experiencing mental illness and highlights a range of programs and initiatives delivered to support education, training and employment opportunities.

[5] National Mental Health Reform Budget tatement by Roxon, the Hon Nicola MP, Macklin, the Hon Jenny MP, and Butler, the Hon Mark MP, 10 May 2011

Summary of Proposals

The Queensland Government makes 16 proposals for the Inquiry's consideration.

Proposal 1:
With particular reference to the Henry Tax Review, it is recommended that the Australian Government examine and remove any remaining financial disincentives to workforce participation created by the interplay of income support and the taxation system, for example marginal tax rates

Proposal 2:
That the Australian Government ensure that any reforms to transition people with mental illness from the Disability Support Pension into employment or training is cognisant of the need for:

a) Centrelink and mainstream employment services to be aware of and take into consideration mental illness and its varied impact on an individual's capacity to participate in employment, and support an individual's ability to improve work performance by accommodating a broader scope of hours and activities within the meaning of 'employment';

b) supportive intensive specialist employment services for people with mental illness to ensure they can both access and maintain employment; and

c) certain groups which feature a large proportion of people with mental illness, such as homeless populations, to be given intensive support beyond employment support in order to access and maintain employment. This includes personal support, supported training, support for employers, housing and tenancy support and access to health care.

Proposal 3:
That the Australian Government develop and implement a targeted campaign, in consultation with states and territories, to educate all Australians on mental illness in the workplace, and educate employers and workers on how to obtain support for people experiencing mental illness at work.

Proposal 4:
That Medicare Locals be required to engage with employment, education and vocational support services within their regions as part of planning and program development processes.

Proposal 5:
In recognition of the challenges facing people with complex needs seeking to transition into the labour market, employment support programs need to be intensive and long term, relative to the level of disability caused by the mental illness as well as the individual's history and circumstances.

Proposal 6:
That the Australian Government support the promotion of employment specialist initiatives, such as the Queensland Health Employment Specialist Initiative, for all States and Territories. Under this model employment specialists from Disability Employment Service providers, funded by the Department of Education, Employment and Workplace Relations, would work within public mental health service teams to support employment outcomes for people experiencing severe mental illness.

Proposal 7:

That the Australian Government review *Evidence and experience – report on the Individual Placement and Support project for disadvantaged job seekers with mental health issues*, to inform development of employment support programs for DSP recipients.

Proposal 8:
That the Australian Government partner with states and territories to showcase existing vocational rehabilitation and mental health projects. The showcase would aim to maximise the spectrum of evidence based practices, including initiatives working with Indigenous communities. The demonstration projects should highlight different partnership models and service delivery locations – urban, rural and regional – throughout Australia. This could occur through implementation of the Fourth Plan's social inclusion and recovery priority area.

Proposal 9:
That the Australian Government consider the development of nationally accredited training in psychiatric vocational rehabilitation and promotion of the training to the vocational, mental health, disability support and training and education sectors.

Proposal 10:
Medicare Locals should explicitly encourage care facilitators to consider vocational and educational support services as part of the non-clinical support component of the initiative. This would entail the facilitator developing linkages with other service providers, and also raising awareness amongst ATAPS service providers about the availability of those services for people experiencing mental illness.

Proposal 11:
To support Aboriginal and Torres Strait Islander peoples with mental illness, the Australian Government should investigate the applicability of labour market programs that might, for example, include intensive one to one support and mentoring by Indigenous employment support officers.

Proposal 12:
Gender analysis should be applied in the development and evaluation of policy and programs to ensure gender equality in access and outcomes.

Proposal 13:
The Australian Government develop an education campaign, in consultation with states and territories, that provides education and practical support for employers, including education on employer and employee rights and responsibilities in respect of mental illness.

Proposal 14:
Consideration should be given to national accreditation bodies including mental health first aid within other first aid courses in both the workplace and the general community.

Proposal 15:
That the Australian Government fund the research and development of treatments for mental illness which would increase a person's ability to participate in work or education, and make evidence-based pharmaceutical treatments accessible through the Pharmaceutical Benefits Scheme.

***Proposal 16*:**

That the Australian Government accept voluntary work as a legitimate and valued activity in the design of any new employment support programs.

Section One: Barriers to Participation in Education, Training and Employment of People with Mental illness

The issues facing people with a mental illness vary with the extent of the impact of their illness. However, mental illness has been identified as a key characteristic among those who are considered to be socially excluded and who face multiple and complex barriers to participating in the labour market. Barriers include the symptoms and treatment of mental illness itself, along with circumstances which may coincide with mental illness. These include alcohol and drug abuse; homelessness; low skills; limited experience; family breakdown; social isolation; inter-generational poverty; cultural differences and frequently, physical ill health. Importantly, a key barrier is the stigma associated with both mental illness and these often-associated circumstances. Mental health issues are a significant issue for many people who are either long term unemployed or outside of the labour market.

Each of these issues represents a significant barrier to workforce participation however for people with mental illness, they are often enmeshed. Given the intertwined nature of the issues there is a need for approaches to supporting people with mental illness to be holistic and coordinated with each other.

"Even though the rates of unemployment among people with mental illness are high, a large proportion of people see it as an important part of their recovery with mental illness and want to work."

— Blueprint: Employment and Psychiatric Disability, SANE Australia 2003.

Employment in the open employment market is the most frequently-identified long-term goal of people with mental illness[6]. Unpublished data from the Early Psychosis Prevention and Intervention Centre (EPPIC) group program shows that vocational rehabilitation is second only to social inclusion as a goal for young people with psychosis attending that program (even above illness recovery). Other research has found that employment is the number one goal of first episode psychosis clients, again above illness recovery[7].

A study of people with acquired brain injury in 2002[8] also has applicability to people with a mental illness. It found that work was a vehicle to re-establishing their lives, but that the job needed to be relevant to their sense of self - future and past. That is, the right job was their priority, not any job. Given the life circumstances such as employment background or education level in which many people acquire their illness, it is important not to devalue the individual's place in setting their own goals and aligning work with their values, skills, and aspirations.

1.1 Individual factors

It may be self-evident that illness disrupts a person's capacity to earn an income or participate in education or training. As with physical illness, the extent to which capacity is affected varies with diagnosis, from anxiety and affective disorders through to schizophrenia and other more serious illnesses; and with the severity of one's condition, which can vary within any individual at any point in time. Mental illness also interrupts one's ability to earn an income while undertaking education and training, which for many is an important career strategy and pathway out of poverty.

[6] Rogers et al, 1991; Secker et al, 2001
[7] Ramsay et al.,submitted
[8] Brain Injury Australia, 2002

People with psychiatric disabilities not looking for work predominantly report the reason for that as being due to their health or that looking for work was 'not applicable'. This is even more pronounced for people with schizophrenia.[9] Tertiary and vocational attainment is much less for those with schizophrenia and other psychiatric disorders than for the general population. The difference is smaller in the case of people with affective or anxiety disorders.

The type of mental illness suffered can impair a person's ability to participate, concentrate and socialise. To assist people experiencing mental illness to participate in education and training, employment service providers need to be provided with education and knowledge around mental illness and its impacts.

Medication

Treatments for mental illness, as well as the symptoms of illness, can become barriers to education, training and workforce participation. Some medications have side effects on mood, behaviour, and cognitive functioning. These side effects can restrict the type of work or study which can be successfully performed, the number of hours work or study can be performed and can negatively affect social skills – and in turn, vocational outcomes.

People prescribed dexamphetamine are also often prescribed sleeping tablets to counter the effects of the amphetamines and this may impact on their ability to participate in morning activities.

Episodic nature of illness

Work absences due to the episodic nature of mental health problems and discrimination associated with mental illness in the work place results in high levels of unemployment and low levels of workforce participation. When episodes occur they can be highly traumatic and weaken the ability of an individual to commit to longer term goals.

Frequent disruption to schooling can lead to a lack of completion of formal schooling and facilitate a downward spiral into social exclusion, low skilled/low paid employment and welfare dependence.

When a person is not experiencing symptoms, support needs can be underestimated, and a lack of ongoing support when the person is apparently well, can lead to relapse and reduced ability to manage common workplace stressors.

Comorbidity

There is a high rate of comorbidity of mental illness with alcohol and other substance abuse. Estimates on the scale of dual diagnosis in Australia vary, but include:

- Approximately 25 per cent of people with anxiety disorders, affective disorders and substance use disorders also have another mental disorder;
- Around 64 per cent of psychiatric in-patients may have a current or previous drug use problem;
- Around 75 per cent of people with alcohol and substance use problems may have a mental illness; and
- About 90 per cent of males with schizophrenia may have a substance use problem[10].

[9] Waghorn et al, Psychiatry Research 186 (2011) 109 – 116 (Author's own copy).
[10] Victorian Government, Better Health Channel

Comorbidity can lead to exclusion from vocational and educational support services aimed at people experiencing mental illness due to associated challenging behaviours including self-harm and aggression; avoidance of services; and resistance to, or non-compliance with, treatment and recovery programs.

Research suggests that people with a dual diagnosis respond well to integrated programs that address both their mental illness and their substance abuse[11]. Queensland has recently restructured its drug and alcohol strategy and treatment units to more closely align drug and alcohol treatment with mental health care.

1.2 Systemic factors

Stigma

Although stigmatising attitudes and discrimination are not confined to people with a mental illness, evidence suggests that the general public respond more negatively to people with psychiatric disabilities than they do to people with physical illnesses[12].

Stigma and discrimination are frequently identified as barriers to employment[13]. People who live with a mental illness often have to cope not only with the condition itself, but also with the multiple disadvantages that arise through public and personal reactions to mental illness. The stigma and discrimination that is associated with mental illness is widespread, and can affect every area of a person's life, including their home and family life, leisure time, access to or engagement with appropriate health care, education and employment[14,15].

Many people with mental illness often find that they face discrimination and stigma by openly disclosing their mental illness to their boss or work colleagues. Disclosure can leave them vulnerable to bullying and harassment, while they can fail to obtain workplace support (resulting in loss of employment) if they do not disclose their illness[16].

Stigma and negative attitudes towards people who experience mental illness by employment officers and work colleagues can both reduce confidence and lead to a decline in wellbeing. Reducing the stigma and discrimination associated with mental illness is an area increasingly being recognised at a national and state level as requiring concerted and coordinated efforts, for example through the Fourth Plan and *Queensland Plan for Mental Health 2007 – 2017*.

Limited employment markets

While there may be labour and skills shortages at present in Australia it must be noted that there are industries and locations that are not conducive to participation by people experiencing mental illness.

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[11] Victorian Government, Better Health Channel. http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Dual_diagnosis

[12] Socall, D.W. and T. Holtgraves, *Attitudes toward the Mentally Ill: The Effects of Label and Beliefs.* The Sociological Quarterly, 1992. **33**(3): p. 435-445.

[13] For example - Australian Social Inclusion Board, 2010; http://www.socialinclusion.gov.au/LatestNews/Pages/HowAustraliaIsFaring.aspx ; Rishworth, Amanda MP, 2011. http://www.aph.gov.au/house/committee/ee/mentalhealth/video_transcript.htm National People with Disabilities and Carer Council, 2009. *Shut Out : the experience of people with disabilities and their families in Australia*. http://www.fahcsia.gov.au/sa/disability/pubs/policy/community_consult/Pages/default.aspx

[14] Byrne, P., *Psychiatric stigma.* The British Journal of Psychiatry, 2001. **178**(3): p. 281-284.

[15] Byrne, P., *Stigma of mental illness and ways of diminishing it.* Adv Psychiatr Treat, 2000+. **6**(1): p. 65-72.

[16] [16] Sainsbury R, Irvine A, Aston J, Wilson S, Williams C and Sinclair A, *Mental Health and Employment (Research Report No 513),* Department for Work and Pensions, London, 2008

For example, the trade sector was the greatest contributor to Australia's and Queensland's economic growth in 2009 – 2010[17], and this is largely driven in Queensland by the mining and resources industry. This industry has features which are known to exacerbate poor mental health. These include fly-in, fly-out arrangements which impact on family life and support networks, isolation, dangerous work environments, and a culture of drug and alcohol abuse in some locations[18].

The construction industry, which is anticipated to experience strong growth as recovery from natural disasters increases, has suicide rates reportedly 75 per cent above other industries. A 2006 study by the Australian Institute for Suicide and Prevention found that Queensland Commercial Building Construction Industry employees aged 15 to 24 had a suicide rate of 58.6 deaths per 100,000. That was 2.39 times the national average and almost double the state average[19]. Risk factors are similar to those in the mining and resources industry, including that 98 per cent of the industry is male and may not have a culture of seeking advice about problems; the itinerant nature of the job and periods of redundancy, which affects relationships; long and often hard working hours that affect life outside of work; and a culture of drug and alcohol use and abuse.

Evidence suggests that people with depression and anxiety are more affected by changing labour force conditions than those who are well[20]. Greater labour demand in 2003 was positively associated with increased labour force participation among healthy adults, but a lack of increase in workforce participation by those with anxiety disorders at the same time indicates that strong economic growth is not necessarily sufficient to attract people with severe mental health conditions back to education and employment. Whether this is due to the nature of the jobs available, or mental illness itself, is uncertain but it is likely to be an interplay between the two – for example low skilled, casual work may not be conducive to people experiencing mental illness, as discussed in other sections of this submission. What it does indicate though, is that widely available, accessible and intensive supported employment and education programs will continue to be needed, even in strong economies.

Young people are disproportionately affected by economic downturns. The global financial crisis saw the gap between the youth and the adult unemployment rates more than double. There has been little progress in reducing this gap, despite relatively strong economic growth. Breaks in employment or education have a significant impact on workforce participation across the life cycle and are likely to have a significant impact on mental health for young people.

While economic growth provides opportunities for many Australians, there are demographic and geographic pockets of disadvantage that continue to be left behind. Mental health is a significant concern in many of these pockets.

Housing and Homelessness

[17] Office of Economic and Statistical Research, Queensland Government, 2010. *Annual economic report on the Queensland economy year ended 30 June 2010*.
[18] Centre for Rural and Remote Mental Health, Queensland. *"This place is doing my head in"*: *strategies for building health and wellbeing in the mining and resources sector*. 2010. http://www.crrmhq.com.au/media/CRRMHQ-Mining-Brochure-2010.pdf
[19] Australian Institute for Suicide Research and Prevention, Griffith University, 2006. *Suicide in the Building Construction Industry (2003 – 2006)*
[20] Waghorn, G; Chant, D; Lloyd, C and Harris, MD. *Labour market conditions, labour force activity and prevalence of psychiatric disorders* in Social Psychiatry and Psychiatric Epidemiology Volume 44, Number 3, 171-178.

Mental illness is closely linked with homelessness, although the direction of causality is often unclear. Mental illness may be a consequence of and/or a cause of homelessness. An analysis of data from the Supported Accommodation Assistance Program, conducted by the Australian Institute of Health and Welfare in 2005, found that 12 per cent of clients nationally in 2004-05 suffered some form of mental illness. These clients were more likely to be living in a car, tent, park, street or squat both before and after receiving supported accommodation assistance than clients with other problems. A lack of sustainable housing is likely to be a significant barrier to workforce participation or participation in education or training.

Natural disasters and employment

The impact of natural disasters on mental health is significant with many disaster survivors displaying symptoms of mental illness such as persistent depression and post traumatic stress disorder for the first time. For those already experiencing serious mental illness, psychoses may re-emerge and recovery slowed. Employment opportunities, especially casual and part-time jobs, are diminished as businesses are forced to close and/or rebuild. The stressors relating to employment, financial hardship and potential relocation away from support systems are amplified and act as a barrier to both recovery and education, training and employment.

Education and Training

There are many barriers to participation in education and training by people experiencing mental illness. These include a lack of accessibility to mental health specialists, for example child and youth mental health services which is even more problematic in remote locations or as a result of socio-economic influences, and difficulties with information sharing between relevant stakeholders.

Focusing the public, private and non-government parts of the vocational education and training sector on equity and social inclusion outcomes in terms of entry-level skills and preparation, adjustments to learning, teaching and assessment designs, learning support services and flexible delivery and assessment arrangements incurs costs to training providers. Without additional funding support, this represents a barrier to achieving change in that sector.

Lack of support for employers

There is little support available for employers to employ a person who has a serious mental illness (for example through a specialist employment program), or a person who is experiencing mild to moderate mental illness. While large scale employers such as banks, some mining companies and government agencies are more likely to have human resource management structures and employment policies such as reasonable adjustments to work and employee assistance schemes, this is by no means the norm for small to medium enterprises. Emerging skills and labour shortages will provide additional incentive for employers to look to non-traditional skills and labour supply, however solutions such as increasing wages and migration remain attractive and immediate fixes.

Complaints based anti-discrimination legislation

Employers are bound by the *Commonwealth Disability Discrimination Act 1992* (DDA) and equivalent state and territory laws make it unlawful to discriminate against, harass or victimise people with disabilities or their associates – including in employment (and accessing or sustaining employment). Further, the *Fair Work Act 2009* requires employers to take adequate steps to ensure occupational health and safety, which includes mental health considerations. However anti-discrimination laws are applied through a complaints-based system, in which complaints can be difficult to prove and the system difficult to navigate, where a person is experiencing

mental illness. These can be disincentives to following up alleged incidents of discrimination against people with mental illness.

Acknowledgement of different types of work: volunteer and paid employment
The Queensland Government is committed to valuing volunteers, the contribution that volunteer workers make and the opportunities that volunteering affords for all people to build vocational skills and connect with others.

Volunteer work might involve flexible hours, with limited pressure, as opposed to paid work with longer hours, role expectations and requirements to report responsibilities to Centrelink. All of these features can make it an attractive occupation or pathway to paid employment for a person disabled by mental illness. However Disability Support Pension (DSP) criteria limit the maximum number of hours a person can 'work' before the pension is cancelled, which can act as a disincentive to volunteer work. Volunteer work should be respected and valued as an end in itself and acknowledged as a pathway to education and training, through measures such as recognising voluntary work as an acceptable activity along with job search and work and study activity for DSP recipients.

1.3 Specialist service system factors

Income support
The structure of Australian Government employment support programs and income support payments, and the interplay between the taxation system and the income support system, present a range of barriers to people experiencing mental illness. Approximately 28 per cent of DSP recipients have psychiatric or psychological conditions as their primary source of disability[21], a not insignificant proportion of the DSP population. Many of these are outlined in the Australian Government's 2009 Pension Review[22] and the Henry Tax Review[23].

There have been disincentives to workforce engagement built into the income support system, for example in respect of pension or benefit withdrawal rates when a person begins to earn some income. The Queensland Government is pleased to see some of these disincentives addressed in the Australian Government's 2011 – 2012 budget announcements. People with mental illness who return to the workforce often fear, sometimes with justification, that reporting their earnings to Centrelink will result in a loss of pension or related benefits. As well as reduced income in the context of what is often an already precarious employment situation, the loss of associated benefits (such as a health care card) can especially be an issue for those who take numerous medications and find that should they lose eligibility, medical costs would rise from $6.00 per item up to $33.00 per item. This increases the risk of a lack of compliance with medication and consequent lack of wellbeing and vulnerability to relapse. The new measure to allow DSP recipients to work up to 30 hours per week for up to two years before losing entitlement to such benefits is welcomed.

A recent study by the Brotherhood of St Laurence has placed the Effective Marginal Tax Rate (EMTR) as high as 80 per cent for families earning 60 – 70 per cent of average earnings. Income support recipients face EMTR's of over 50 per cent when

[21] Australian Government, 2009 cited in Waghorn et al, 2011, in press.
[22] Harmer, Jeff, Department of Families, Housing, Community Services and Indigenous Affairs, 2009. *Pension Review Report*.
[23] Australian Government, 2010. *Australia's Future Tax System*. http://www.taxreview.treasury.gov.au/content/Content.aspx?doc=html/pubs_reports.htm

consideration is given to withdrawal of income support, concessions and rebates including public rent rebates.[24] This represents a significant disincentive to workforce participation.

Proposal 1:
With particular reference to the Henry Tax Review, it is recommended that the Australian Government examine and remove any remaining financial disincentives to workforce participation created by the interplay of income support and the taxation system, for example marginal tax rates .

The episodic nature of many mental illnesses can mean employment arrangements, and the need for income support and for engaging with the income support and employment service systems changes frequently.

A recent Commonwealth Ombudsman's report[25] outlines complaints from people living with a mental illness who have experienced difficulty when interacting with Centrelink and employment service providers. Problems include:

- being required to comply with payment conditions that do not allow for the limitations posed by the customer's illness;
- being subjected to communication or claim arrangements that do not take into account the barriers posed by the illness; and
- being required to re-tell their 'story' to each new person they encounter in the system.

The report identifies several key areas which need to be addressed if the social security system is to more effectively support customers with a mental illness:

- greater consideration of a customer's barriers to communication;
- more training for staff to identify possible customers with mental illness;
- encouraging customers to disclose a mental illness; and
- better recording of information about a customer's illness or barriers to engagement.

The report makes 11 recommendations to improve policy and procedures, encourage staff to better match services and payments to customer circumstances, reduce distress and disadvantage that people with mental illness problems encounter in the system. The Queensland Government understands that Centrelink and other relevant agencies have agreed to implement many of the recommendations made by the Commonwealth Ombudsman.

The report notes that the Australian Government's Department of Education, Employment and Workplace Relations is developing a best practice guide to employment assistance specifically for people with a mental illness. The Queensland Government supports this step and notes that the Fourth Plan will also focus on improving employment participation for people experiencing mental illness.

[24] Bodsworth E, *Making Work Pay and making income support work*, Brotherhood of St Laurence, Fitzroy, 2010
[25] Commonwealth Ombudsman, 2010. *Falling through the cracks—Centrelink, DEEWR and FaHSCIA: Engaging with customers with a mental illness in the social security system*

A new measure announced by the Australian Government in its 2011 – 2012 budget is that DSP recipients aged under 35 able to work eight hours or more a week will be required to attend Centrelink interviews to create an individual participation plan. It is hoped the additional funding for Department of Human Services staff, and reforms to employment services, will increase the ability of the income and employment support systems to respond to the particular needs of people experiencing mental illness.

Proposal 2:

That the Australian Government ensure that any reforms to transition people with mental illness from the Disability Support Pension into employment or training is cognisant of the need for:

a) Centrelink and mainstream employment services to be aware of and take into consideration mental illness and its varied impact on individual's capacity to participate in employment, and support an individual's ability to improve work performance by accommodating a broader scope of hours and activities within the meaning of 'employment';

b) supportive intensive specialist employment services for people with mental illness to ensure they can both access and maintain employment; and

c) certain groups which feature a large proportion of people with mental illness, such as homeless populations, to be given intensive support beyond employment support in order to access and maintain employment. This includes personal support, supported training, support for employers, housing and tenancy support and access to health care.

Disability Employment Services

The Australian Government's Disability Employment Services (DESs) are a key support service for people with a mental illness, yet they do not routinely have expertise around mental illness or partnerships with mental health services. The Australian Government has committed to consider this, in its response to the above-mentioned 2010 report by the Commonwealth Ombudsman. It should be noted that as well as people with a mental illness being a target group for this service, people with a disability (the primary DES target group) have a higher rate of mental illness than the general community. Some studies suggest that prevalence of mental illness in persons with intellectual disability is roughly twice that of the general population[26] and another paper reports that there is a 40 per cent risk of people with intellectual disability developing a mental illness[27]. Improved expertise around mental health is clearly an area worthy of focussed attention for these services.

An additional difficulty with the DES being the principal employment support initiative for people with a mental illness, is that people with a mental illness do not necessarily see themselves as having a disability and perceive that they may be stigmatised by using a service targeted at that population group. Developing formal partnerships with mental health services, for example as occurs with Queensland's Employment Specialist Initiative, could address this for people with a severe mental illness. Formal partnerships with other universal employment and community services (government and non-government) could also address this issue.

[26] O'Neal, 2005, Cited in Welsh, Andrew, 2009. *Identifying challenges and approaches in working with people with co-existing intellectual disability and mental health issues.* Paper to 9th Annual DSW conference Melbourne, 18-19th November 2009

[27] Einfeld, 1996. Cited in Welsh, Andrew, 2009 (ibid).

Poorly coordinated service provision

There is considerable emphasis on improving human service coordination in all sectors, in recognition that historical 'siloed' service provision does not lead to good outcomes for either service users or service providers. Improving collaboration between the public sector, private sector, non-government organisations, government agencies and departments and broader community is a critical aspect of the *Queensland Plan for Mental Health 2007 – 2017*.

The variety of services used by people experiencing mental illness generally are not integrated and this can lead to services not being provided where they are needed, one service impacting negatively on another service used (e.g. disincentives to volunteering within Centrelink's income support system), and a lack of continuity of service support. For people experiencing mild and relatively short term mental illness this may not be such an issue as it is for those with a more severe mental illness. For that group, services across sectors need to be integrated to ensure the best outcomes are received. This includes services supporting social and economic participation, as well as clinical services, and should include communication protocols, information sharing processes and clear referral pathways.

Queensland's Care Coordination model (see section 2.2) aims to allow various services from all sectors to work together as a single system of care for individuals with a severe mental illness. The 2011 – 2012 federal budget announcement of funding for Care Facilitators around the nation will add to this effort.

Access to medical treatment

Access to ongoing mental health and physical health services to support people as they recover and seek to participate in education, training and employment, is essential. People with a severe mental illness have among the worst physical health of any population sub-group, with life expectancy around 12 years less than the general population[28]. This is not solely a result of suicides amongst people with mental illness, as suicide was the fifth most common cause of death [29] Access to physical health care by people experiencing mental illness poses a barrier to employment, with physical health issues continuing to limit access to work and training even when a person is mentally well enough to work.

Mental health support services (both clinical and non-clinical) for people who have experienced mental illness can cease when they are well – whether through consumer choice or service provider demand management. A limited supply of general and ongoing mental health support for people experiencing, or who are at risk of experiencing, mental illness poses another barrier to workforce participation.

1.4 Subpopulation factors

It is also important to note that there are some groups in our community who face compounding disadvantage, which when combined with mental illness poses additional barriers to those faced by all people who have mental illness.

[28] Coghlan R, Lawrence D, Holman CDJ, Jablensky AV . *Duty to care: Physical illness in people with mental illness*. Perth: The University of Western Australia, 2001. [CVD ➔ 16% of excess mortality, Suicide ➔ 8% of excess mortality.]

[29] Lawrence D, Coghlan R. H health inequalities and the health needs of people with mental illness. *NSW Public Health Bulletin 2002*; 13(7): 155– 158.

Indigenous Peoples and Communities

Queensland is home to the second largest Aboriginal and Torres Strait Islander population in Australia. The Queensland Aboriginal and Torres Strait Islander population is diverse, and is nationally unique in that it encompasses two very distinct Indigenous cultures; Aboriginal peoples and Torres Strait Islander peoples. Torres Strait Islanders have a distinctive regional identity. It is also important to note that there are a number of differences between the various Islander communities.

The well documented significant disadvantage experienced by Aboriginal and Torres Strait Islander people in relation to education, training and employment is compounded by issues relating to mental illness. 2005-06 data[30] indicates that hospitalisation rates for Aboriginal and Torres Strait Islander people for 'schizophrenia, schizotypal and delusional disorders' were almost double those for non-Indigenous males and females.

Experiences of violence and trauma have a significant impact on the mental health and emotional and social wellbeing of all individuals. A significant number of Indigenous people, particularly Indigenous women, experience violence, which increases their risk of mental illness.

Aboriginal and Torres Strait Islander people in general face significant barriers in accessing and maintaining employment and training. In 2007 Aboriginal and Torres Strait Islander workforce participation rates were closer to 30 percentage points lower than non-Indigenous workforce participation rates. Stigma and marginalisation amongst Aboriginal and Torres Strait Islander people entering the employment and training sector can lead to exclusion and low income, a loss of self confidence and isolation — all of which can impact on mental health, whether or not there is pre-existing mental illness.

There is a lack of mental health services and formal support for people with mental illness who live in rural and remote communities; and poor linkages between private, government and specialist health services. There are also poor linkages between health services and other support services that might support an Indigenous person to access and maintain employment and training. Health and other support systems have a workforce which is largely non-Indigenous, not trained in issues relevant to Indigenous individuals, families and communities and generally reluctant to work in rural and remote areas. The QPMH has a priority area around workforce capacity, and this issue is being considered in the development of resulting workforce strategies.

There are financial barriers to the provision of private and community based health care including up-front fees for services and medications.

Additionally, there is a lack of culturally appropriate resources to educate Aboriginal and Torres Strait Islander people about mental health issues. Queensland has recently developed culturally appropriate Mental Health First Aid training and a range of other resources for Indigenous people to address this barrier (see Section 2.3).

Young People

In a competitive job market, a lack of experience makes it harder to overcome the barriers identified for all people experiencing mental illness.

[30] ABS, 2009

Anti-psychotic medication can have side effects for all people, including sedative effects. For young people in their teens, who are also experiencing physical changes that impact on sleeping patterns quite separately from any medication effects, the side effects can exacerbate difficulties in getting up to go to work, school or any other early morning commitment.

Shift work can impact negatively on recovery for all people, in terms of its impact on body clocks. Shift, or irregular, work is often what is available for young, unskilled and inexperienced people.

People from culturally and linguistically diverse backgrounds

People from culturally and linguistically diverse (CALD) backgrounds with mental illness experience the same barriers to employment, education and training as the general population with mental illness exacerbated by a number of cultural and linguistic factors contributing to lack of awareness of available programs. Generally people from CALD backgrounds who experience mental illness are under represented across the spectrum of mental health and related support services, and specific programs with targeted strategies of outreach and culturally appropriate support are required to overcome these barriers.

Barriers to employment and participation in training programs exist for the CALD community in general and those experiencing a mental illness are doubly disadvantaged. There are few employment, training or education support programs that specifically target people from CALD backgrounds who experience mental illness=. Additional factors that need to be taken into consideration include that it may be important to work with the family unit as cultural and familial attitudes towards mental illness are often a contributing factor to the individual with mental illness not participating in employment or training.

People from refugee backgrounds may experience additional barriers relating to pre-migration experiences such as trauma and may require additional support to facilitate their participation due to lack of resources.

Women

Research has identified access to economic resources (work, education, housing and money) as one of the central determinants of mental health.

However, many women with mental illness face double disadvantage due to gendered trends in education, training and labour force participation, which result in barriers to their involvement: in particular, the concentration of women in the low paid, casual workforce.

Women's patterns of work and care, their disproportionate responsibility for unpaid work, and their lower pay relative to men manifest in unequal participation in the workforce. This, combined with a high burden of disease for anxiety and depression, and susceptibility to postnatal depression, may impede women's ability to participate in education, employment and vocational programs.

The prevalence of mental illness among people who are homeless has been noted as substantially greater than rates of mental illness in the general population. This could contribute to their access to employment, education and training. Increasing numbers of older women (those over 45 years of age) are entering the homeless population for the first time, with more older women than older men now entering supported accommodation and compelling evidence existing of high levels of housing risk for single, ageing women.

Targeted consultation with the women's sector is one way to overcome these barriers by ensuring the views of women with mental illness are captured, and providing the opportunity for any gendered issues to be identified and addressed.

Carers

Informal carers provide an invaluable contribution to both the people they care for and the broader community. They perform essential roles and provide support, nurturing and friendship to the people they care for. The 2006 ABS Census of Population and Housing indicates that 293,723 people in Queensland are reported as providing informal (unpaid) support to family members (or others) with a disability, a long term illness or problems relating to old age. Additionally, research shows that women are much more likely than men to be carers (17 per cent of women and 14 per cent of men) and that many carers struggle to maintain employment due to the demands of the caring role.

Maintenance of the mental and physical health and wellbeing of carers is an important aspect to supporting not only themselves but also to enabling the people they care for to engage in education, training and employment. This issue is worthy of further examination during the course of the Inquiry.

People exiting correctional facilities

Offenders are a significantly disadvantaged group, with the majority experiencing overwhelming barriers to education, training and employment in the community. Barriers can include having a history of poor participation in education and employment, high rates of substance abuse and impaired cognitive functioning.

In Queensland there are approximately 1,200 prisoners in custody who are receiving treatment within the Prison Mental Health Service. Of these:

- 10 per cent of patients are female;
- 24.5 per cent of male patients identify as Indigenous Australian; and
- 37.5 per cent of female patients identify as Indigenous Australian.

There are limitations to this data as it does not capture prisoners who are not current users of the Prison Mental Health Service who have a history of mental illness or whose mental illness is managed through contact with a consultant General Practitioner.

Of offenders on probation and parole, 22 per cent have been identified as having current or previous mental illness issues or as being court mandated to undergo a medical/psychological/psychiatric evaluation.

Upon exiting a correctional facility many prisoners experience barriers to the basic precursors to engagement in education, employment and training, such as appropriate housing and support. This can impact on a person's ability to consider education, training and employment as viable options. These disadvantages are further compounded by the social stigmatisation of a criminal history.

For offenders with mental illness supervised by probation and parole, employment, education and training assistance can be difficult to access. Some of the barriers to accessing assistance in the community can include, but are not limited to:

- the location of the offender in proximity to service providers;

- the availability of agencies to assist offenders in accessing education, training and employment;
- waitlists for access to support agencies in the context of the length of supervision;
- existing work readiness issues and employability skills;
- offender mental health treatment non-compliance; and
- comorbidity of mental illness and substance abuse issues.

Section Two: Ways to Enhance Access and Participation in Education, Training and Employment of People with Mental illness through Improved Collaboration Between Government, Health, Community, Education, Training, Employment and Other Services

2.1 Mainstream service system responses

All service systems will at times support people who have mental illness, given that around 20 per cent of the population will experience mental illness at some point in their lives. A lack of access to general social and economic supports contributes to restricted participation in employment and in the broader community. An understanding of mental health issues and how it might affect support needs is therefore an important requirement for all social and economic support services, and for the community at large.

"…the specialised vocational knowledge needed for identifying and overcoming barriers to employment among people with a mental illness, needs to be available to staff of non-specialised services, employers, consumers, carers, clinicians and mental health staff in community health care settings" [31]

Stigma reduction

Activities and strategies that aim to address stigma and discrimination should be targeted towards a range of key influence groups and settings that are known to have the greatest impact on stigma and discrimination.

Key influence groups are those who have a high level of contact with people with a mental illness and are either more likely to hold stigmatising views of mental illness, or are in a position to positively impact on the stigma and discrimination that people with a mental illness experience. Key influence groups include frontline service providers across the health, law enforcement, emergency services, welfare, and housing sectors, employers and the media. Key influence settings are those where stigma and discrimination against people with mental illness has the greatest impact, including health services, workplaces and housing services.

Targeting key influence groups and settings, such as employers and workplaces, has more impact on improving the experiences of people with a mental illness than broad based public education campaigns.

Mainstream vocational plans, and mental health Recovery Plans including a vocational element, could also include stigma reduction and stigma management strategies to support individuals to address one of the key barriers to participation in open employment, education or training.

In addition to reducing stigma and discrimination among frontline workers in the education and employment sectors, care must be taken to ensure that recruitment and retention strategies are non-stigmatising, while promoting inclusion of people with a mental illness.

[31] Waghorn, G and Lloyd, C, 2005. *The Employment of People with Mental Illness*, p29.

Proposal 3:
That the Australian Government develop and implement a targeted campaign, in consultation with states and territories, to educate all Australians on mental illness in the workplace, and educate employers and workers on how to obtain support for people experiencing mental illness at work.

Medicare Locals
In recognition of the multiple factors that impact upon individual and population health, including mental health, Medicare Locals should be required to develop linkages with the broad range of services that impact on people's health, including access to employment, training and education. This could extend to conducting joint planning processes and collaborating on program development, ensuring health service providers are aware of these other services and their relevance, and vice versa.

Proposal 4:
That Medicare Locals be required to engage with employment, education and vocational support services within their regions as part of planning and program development processes.

Mainstream employment programs
Experience in Queensland in the delivery of employment programs has highlighted two models that can be used to assist individuals with mental illness. The two models are outlined in Appendix 1.

The first model uses mainstream employment programs, but integrates a range of support services, including mental health. Integrated Case Management offers long-term individual case management that provides individuals with the support they need to address their personal barriers to employment. The use of formal multi-agency teams brings together service providers in a local environment to streamline referrals. This approach does not specifically target individuals with a mental illness, but looks to target individuals with a range of barriers as it provides the flexibility to meet the range of individual needs.

Based on state and national priorities and the needs of communities in Queensland, employment programs target youth, Indigenous communities and jobless households. It is known that mental illness is a significant issue for many individuals in these population groups, and so addressing mental health is a key part of the support needed to enter or re-enter the workforce. The use of flexible case management models to support these individuals will use expertise in the community and build customised support, including mental health support.

This approach is supported by a Queensland study into the measurement and costs of social exclusion. This research found that labour market and training programs need to change emphasis from single issue approach to one based on a significant component of case-management[32].

[32] Mangan J and Stephen K, Social Exclusion in Queensland: Measurement and Cost

Education and Training

The concept of 'reasonable adjustment' is actively applied in the Queensland Government's vocational education sector (TAFE Queensland). The *Reasonable Adjustment in teaching, learning and assessment for learners with a disability: A guide for VET practitioners*, provides teachers, trainers, disability practitioners and educational managers information and practical strategies for applying reasonable adjustment in teaching, learning and assessment. A number of professional development activities are undertaken to facilitate this.

In Queensland state schools, access to specialist support is available for staff and students, and cross-sectoral linkages are in place to build capacity for mental health promotion, illness prevention and early intervention.

The Queensland Ed-LinQ initiative (Ed-LinQ) is a key initiative under the Queensland Plan for Mental Health 2007-2017. Ed-LinQ has been developed in partnership with the government, independent and catholic education sectors. The initiative aims to improve communication, coordination and collaboration between the education sector, the primary care sector and the mental health sector, with the aim of improving social and emotional outcomes for students.

The Queensland Ed-LinQ initiative works strategically at a state and district level to support child and youth mental health services, the education sector and the primary care sector to work collaboratively to enhance the early identification and treatment of emerging mental illness in school-aged children and young people.

It is envisaged that as a result of the Queensland Ed-LinQ initiative:

- School staff will know how to identify when a student is at risk of, or is experiencing, mental illness.
- School staff will have access to information regarding comprehensive local referral and care pathways.
- Appropriate services will be accessed to provide advice, assessment and intervention for identified students.
- This process will be supported by strong strategic links at the local level, improving access to key resources.
- This process will be supported through a focus on developing the skills and knowledge of key education and primary care stakeholders.
- Ultimately, there will be an overall improvement in the mental health outcomes of Queensland school students.

Work is also progressing to build individual school capacity to support all students by collaborating, networking and establishing partnerships with other service providers. This will be supported by the Community Mental Health Workforce Strategy, which has a focus on building partnerships between various stakeholders in the community mental health workforce. This includes service providers, government agencies, education and training providers, unions, professional associations, related sectors and communities. Further information is included within Appendix 1.

School participation is an integral part of care planning for students requiring clinical intervention. Schools support students' mental health and social and emotional wellbeing by working in partnership with parents, clinical care providers and specialist mental health services, to ensure that they are supportive and engaging places for all students, staff and school community members.

Where a student has been determined to have a mental health difficulty, schools may implement reasonable educational adjustments to the curriculum, learning environment, attendance and disciplinary procedures, as described in the department's *Supporting Students' Mental Health and Wellbeing* policy.

Schools also adopt whole-of-school approaches to promote and support students' social and emotional development, (e.g. School-Wide Positive Behaviour Support, KidsMatter, and MindMatters) and build the capacity of all school staff to cater for the diverse range of students within the school community. Staff are provided with professional development opportunities to help them better understand and implement these whole-of-school approaches to enhancing student social and emotional wellbeing.

2.2 Specialist Service System Responses

The Fourth Plan has an emphasis on social inclusion and recovery as one of its five priority areas. In Queensland, a range of initiatives are underway to implement the employment and other aspects of social inclusion for people with a mental illness, including the Care Coordination model, the Employment Specialist Initiative and Social Enterprises, all of which are discussed throughout this submission.

A key feature of all of these initiatives is working across service systems and sectors, collaborating, and developing partnerships.

A recent study emphasises the importance of formal partnerships to achieve good vocational outcomes for people with a mental illness[33]. This can occur at a broad systemic level (for example, between the Australian Government's Department of Education, Employment and Workplace Relations and state health departments) as well as through local area partnerships and agreements (for example, as in the Queensland Employment Specialist Initiative).

Successful delivery of employment assistance to any targeted group relies on bringing areas of expertise together; in this case mental health and employment services.

Similarly, strategies to address homelessness in Queensland, in recognition of the need for holistic responses, look to link services such as employment, health and transport around a homeless person, to increase the likelihood of sustaining housing and achieving the broader goals social and economic participation.

Supported employment programs in Queensland

The delivery of employment programs in Queensland through Skilling Queenslanders for Work has highlighted two 'model' approaches that have been undertaken to support individuals with a mental illness. Examples of each model are provided in Appendix 1. These models are based on the categorisation outlined above of either specialist support or integrated case management in mainstream employment programs. Both models look to integrate employment and specialist support services ensuring that assistance is flexible and tailored for individual needs.

[33] Waghorn, G et al, 2011. *Enhancing Community Mental Health Services through Formal Partnerships with Supported Employment Providers*. In press.

Under a specialist support model, a mainstream employment project is embedded within a specialist mental health organisation. This ensures that assistance meets the specific needs of individuals with mental health issues but is also clearly focussed on employment outcomes as a result of the assistance. Under this approach participation in the project is targeted specifically at people experiencing mental illness.

For people with more seriously disabling mental illness, incorporating vocational activity with mental health treatment can increase the likelihood of good vocational outcomes[34]. Treatment and recovery plans for people with a mental illness formally include vocational activities.

Key features of successful specialist employment responses include an individualised approach combined with intensive ongoing support[35]. Specialist services should meet an individual's range of needs and specific goals and circumstances.

Proposal 5:
In recognition of the challenges facing people with complex needs seeking to transition into the labour market, employment support programs need to be intensive and long term, relative to the level of disability caused by the mental illness as well as the individual's history and circumstances.

Disability Employment Services
A recent study emphasises the importance of formal partnerships to achieve good vocational outcomes for people with a mental illness[36]. It contends that integration of specialised employment support with mental health treatment can be viewed as even more critical than integration with housing or personal support services, because treatment plans often need to be modified as soon as a person with a severe mental illness commences employment in order to ensure an optimum level of work performance.

Queensland's Employment Specialist Initiative is an example of a formal partnership approach between Disability Employment Services (DESs) and public mental health services and is discussed below. Lessons learned from this initiative and similar approaches elsewhere indicate that partnerships between mental health and DESs can be readily formalised around a commitment to joint delivery of evidence-based practices in supported employment and education. The model is delivered in the context of supportive social and economic mental health policies, collaboration with other service systems and a demand-driven DES funding system under which supported employment services are paid for employment outcomes. This approach requires continuing joint management and a commitment from both organisations to joint service management, reporting of fidelity to the model and of client employment outcomes along with feedback from key partnership stakeholders.

Queensland's Employment Specialist Initiative
Queensland's Employment Specialist Initiative is a specialist supported employment service for people with severe and recurring mental illness.

[34] Waghorn, G; Childs, S; Hampton, E; Gladman, B; Greaves, Aand Bowman, D. Enhancing Community Mental Health Services through Formal Partnerships with Supported Employment Providers. American Journal of Psychiatric Rehabilitation, in press.
[35] Waghorn and Lloyd 2005, Bond et al 2001 and Mueser et al 1997, both cited in Waghorn and Lloyd 2005.
[36] Waghorn, G et al, 2011. *Enhancing Community Mental Health Services through Formal Partnerships with Supported Employment Providers*. In press.

Integrating vocational rehabilitation services into public mental health services is an essential component in supporting psychosocial rehabilitation for people with a severe mental illness. To this end, partnerships between Queensland Health mental health services and individual Australian Government-funded DES providers has been developed. The partnerships are supported at the state level by Queensland Health. Through the partnerships, an employment specialist, employed by a DES - funded service provider, is physically located within the community mental health team in a mental health service. This offers opportunities to share resources, form common and normalising perceptions of mental health service consumers as job seekers, synchronise employment with health services, and coordinate roles among mental health team members with the employment specialist focusing on work-related issues.

A recent study completed in Australia[37] compared the outcomes of people receiving usual mental health interventions to those receiving interventions in addition to active engagement in vocational placement and support as part of their mental health treatment. This was achieved through having an employment officer on site within the mental health service. Those engaged with vocational placement and support were significantly more likely to have had a job or be engaged in education at six month follow up, were likely to be earning more and were significantly more likely to have transitioned away from income support payments.

Proposal 6:
That the Australian Government support the promotion of employment specialist initiatives, such as the Queensland Health Employment Specialist Initiative, for all States and Territories. Under this model employment specialists from Disability Employment Service providers, funded by the Department of Education, Employment and Workplace Relations, would work within public mental health service teams to support employment outcomes for people experiencing severe mental illness.

Queensland's Care Coordination initiative

Queensland's Care Coordination initiative aims to promote the development of effective working relationships between government, non-government and the private sector to achieve coordinated cross-sectoral support for people with severe mental illness and complex care needs, who are at risk of falling through the gaps in current service provision.

Care Coordination is a flagship initiative of the COAG National Action Plan on Mental Health 2006-2011. Queensland is the only state to have implemented the model on a statewide basis, with specified care coordination positions. Across Queensland 20 Service Integration Coordinators have been appointed to implement the model.

The Service Integration Coordinators work in partnership with government, non-government and private sector organisations including primary health care, employment, housing, education and vocational services at the local level, to coordinate support for people living in the community with a severe mental illness.

A state-level multi-agency memorandum of understanding (MOU) supports local care coordination activity. The MOU provides a mandate and legitimacy for activities at the local level, and this formal partnership between agencies is considered an important element supporting the program's effective operation.

[37] Killackey, Jackson and McGorry, BJP, 193, 114-120 cited in Waghorn et al, 2009.

In Queensland, Care Coordination has well established referral pathways between Queensland Health mental health services (inpatient and outpatient), non-government service providers and private practitioners within Queensland Health districts (future Local Hospital Networks and Medicare Local zones). This includes referral procedures, information sharing protocols, professional networks, co-location of services (for example through the Employment Specialist Initiative) and shared planning processes. Education, training and employment support services operated by the Queensland, Australian and local governments and non-government organisations may all be part of the process, dependent on individual case plans.

Continuity of care for this client group (including continuity of specialist service providers) is enhanced, with people supported as they move through both inpatient and community-based care, in response to changing needs that may be determined by varying levels of incapacity experienced as part of mental illness.

It will be important to ensure that employment, education and vocational support services are included in the non-clinical support which can be purchased through the Australian Government's new Coordinated Care initiative. Further, it will be important to ensure that the Australian Government's Coordinated Care initiative does not duplicate, but complements, Queensland's Care Coordination program.

The Individual Placement and Support model

Queensland sites including the Princess Alexandra Hospital participated in the Individual Placement and Support model, piloted nationally in 2009 and evaluated in February 2010[38]. Unlike the Queensland Health Employment Specialist Initiative, which provides employment services in a mental health service context, under the pilot model mental health services were provided in an employment context. Another difference from the Queensland Health Employment Specialist Initiative is that the model serviced people with multiple barriers to employment, not just mental illness.

Key issues found in the evaluation of the pilots included that contractual obligations on employment service providers made it difficult to implement the model; the stigma associated with receiving specialist support in the workplace made people reluctant to use it; and that significant time, training and resources are required to develop skills in and experience in engaging employers. Further consideration of the evaluation report could support the development of an appropriately modified program.

Proposal 7:

That the Australian Government review *Evidence and experience – report on the Individual Placement and Support project for disadvantaged job seekers with mental health issues*, to inform development of employment support programs for DSP recipients.

Proposal 8:

That the Australian Government partner with states and territories to showcase existing vocational rehabilitation and mental health models. The showcase would aim to maximise the spectrum of evidence based practices, including initiatives working with Indigenous communities. The demonstration projects should highlight different

[38] Bowman, D and Lawlor, J, February 2010. *Evidence and experience – report on the Individual Placement and Support project for disadvantaged job seekers with mental health issues*.

partnership models and service delivery locations – urban, rural and regional – throughout Australia. This could occur through implementation of the Fourth Plan social and economic inclusion priority.

Workforce strategies

To build workforce capacity and support workers to understand the complexity of needs for people experiencing mental illness seeking engagement with education, training and employment, a nationally accredited training package, targeting the vocational education and training and mental health sectors could be developed.

Proposal 9:

That the Australian Government consider the development of nationally accredited training in psychiatric vocational rehabilitation and promotion of the training to the vocational, mental health, disability support and training and education sectors.

Medicare Locals - Access to Allied Psychological Services (ATAPS)

ATAPS is an Australian Government initiative, with divisions of general practice funded to broker or provide services to people with mild to moderate mental illness through community-based service providers. The new flexible care packages component, announced earlier in 2011 to commence from 1 July 2011, will provide funding for Medicare Locals to purchase coordinated clinical and non-clinical services for people with a severe mental illness. ATAPS services are community-based, with service providers including general practitioners, psychologists, social workers and occupational therapists. Given that most people experiencing mental illness who receive treatment receive it in the community, ATAPS is well placed with this additional funding for non-clinical support, and the requirement that packages be coordinated, to purchase employment and vocational support for people with severe mental illness.

With many employment initiatives for people with mental illness delivered through the state, the Queensland Government would welcome discussion with the Australian Government as to how flexible care packages for people with severe mental illness living in the community can realise the best possible social and economic participation outcomes for this population.

On 1 April 2011 the Australian Government announced that the implementation of flexible care packages would be staged, commencing with the implementation of the first Medicare Locals from 1 July 2011 and rolling out as new Medicare Locals commence. There is considerable disappointment at this delay amongst the mental health sector in Queensland.

Subsequently, the Australian Government's 2011 – 2012 budget statement announced an expansion of this program so that it includes funding for care facilitation.

Proposal 10:

Medicare Locals should explicitly encourage care facilitators to consider vocational and educational support services as part of the non-clinical support component of the initiative. This would entail the facilitator developing linkages with other service providers, and also raising awareness amongst ATAPS service providers about the availability of those services for people experiencing mental illness.

Employment and education as a component of mental health Recovery Plans
Queensland is committed to delivering a comprehensive, recovery orientated mental health system and vocational rehabilitation is ideally suited to a recovery framework[39]. Anecdotal reports indicate that recovery plans that include vocational rehabilitation activities …"can deliver new opportunities to observe signs of both recovery and deterioration in mental health, and help prevent relapse, because deterioration is often first observed in vocational rehabilitation activities or in work performance"[40]. Meaningful activities can contribute to the recovery process through active participation in structured social, recreational, volunteer work, arts, and education.

In Queensland, school participation is an integral component of school care planning for students requiring clinical intervention, and in most cases it would also be part of an individual's mental health Recovery Plan. Integrating this formally into Recovery Plans would increase the focus on social and economic participation for people with mental illness. A nationally consistent approach to recovery planning is under consideration as part of work towards implementing the Fourth Plan and this will be considered as part of that work.

Queensland's Consumer Companion Program
Queensland's Consumer Companion Program is based on the concepts of shared experience, learning from one another and having a support from a companion. Through the program, people with a lived experience of mental illness and recovery are employed by state mental health services as non-clinical staff members, to provide a variety of information and education about mental illness, support services and medication to consumers and their families, friends and carers.

This program is recovery-focused and is operational in every acute adult mental health service in Queensland. As well as providing support to people experiencing mental illness in respect of goals and support available to achieve them (including employment and education goals) the program provides consumers with an opportunity to re-enter the workforce once they are in recovery. These roles are provided with ongoing training, supervision and support.

Further activity to increase consumer and carer employment in clinical and community support settings has been identified by all jurisdictions through implementation of the Fourth Plan, priority area 4 — Quality Improvement and Innovation.

Social enterprises
Social enterprises aim to deliver targeted social or community benefits using traditional business principles. In the context of employment for people experiencing mental illness, they provide a low-stigma environment in which people are encouraged and supported towards recovery through social and economic participation. People with lived experience of mental illness are encouraged to develop skills and confidence by working in a social enterprise, including being involved in its management and/or operations, and gain more opportunities to continue along their career pathway. Social enterprises have emerged as an innovative response to create jobs that assist people from disadvantaged backgrounds to engage in the business and social life of their local community. The Queensland Government has developed a strong partnership with Social Ventures

[39] Waghorn and Lloyd, 2005.
[40] Waghorn and Lloyd, 2005, p36

Australia through the Queensland Inclusive Social Enterprise Project (QISEP) that will provide many benefits for communities across the State, particularly people living in rural and remote regions with limited appropriate open workforce participation options.

The aim of the QISEP is to create real jobs for people with mental illness who have experienced long term unemployment. The social enterprises provide supportive working environments that encourage people along their individual journey of recovery. In 2010 in Queensland, nine social enterprises were funded to employ people with mental illness.

2.3 Subpopulation strategies

Indigenous peoples and communities

Queensland is an active partner in the COAG Closing the Gap framework designed to help close the gap in Indigenous disadvantage, including the continued implementation of a range of National Partnership Agreements. COAG has committed to six key targets as part of the Indigenous reform agenda, which include a focus on improved education and employment outcomes.

Mental health issues are often exacerbated by alcohol and drug misuse. To address high levels of violence and associated health (including mental health) impacts in Indigenous communities, an alcohol management reform program has been developed to reduce alcohol supply and demand in communities, as well as to improve alcohol rehabilitation, diversionary and treatment services. In addressing alcohol-related harm, domestic violence and other violent behaviour are reduced, community health, including mental health, is improved, and communities are made safer, especially for women and children.

Aboriginal and Torres Strait Islander people are over-represented in the criminal justice system and the mental health needs and issues of Indigenous prisoners are not always easily diagnosed or addressed. The draft *Aboriginal and Torres Strait Islander Justice Strategy 2011-2014* proposes a range of targets to prevent crime and reduce reoffending through education and improved school attendance, employment and training opportunities for example, improving work readiness for those in prison or detention, many of whom may experience co-existing mental illness.

There is considerable activity around access to employment and education for Indigenous people, by both state, Australian and local governments, which recognises the multiple disadvantages faced by this population. It is important to ensure that this activity is connected with any activity that targets Indigenous people and communities experiencing mental illness.

The development of partnerships and connections between providers of employment, health and other support services, Aboriginal and Torres Strait Islander people and their communities, and employers could assist to address institutional and individual barriers to Aboriginal and Torres Strait participation in the workforce.

Proposal 11:
To support Aboriginal and Torres Strait Islander peoples with mental illness, the Australian Government should investigate the applicability of labour market programs that might, for example, include intensive one to one support and mentoring by Indigenous employment support officers.

The *Queensland Plan for Mental Health 2007–2017*, Queensland's blueprint for reform of mental health services, includes priority actions to reduce suicide risk and mortality among Aboriginal and Torres Strait Islander populations and to employ additional Aboriginal and Torres Strait Islander mental health workers.

The Government has established the Queensland Aboriginal and Torres Strait Islander Hub for Mental Health (QATSIHMH) to lead and govern Aboriginal and Torres Strait Islander mental health initiatives. QATSIHMH's achievements include:

- the appointment of a master facilitator for Aboriginal and Torres Strait Islander Mental Health First Aid (ATSIMHFA) to deliver train-the-trainer courses (75 places over May – June 2011);
- planning for an ATSIMHFA instructor training course to improve capacity to deliver ATSIMHFA in priority areas and communities across Queensland;
- the development of the Cultural Information Gathering Tool (CIGT) to collect cultural information about an Aboriginal or Torres Strait Islander person who is experiencing a mental health crisis; and
- the development of a CIGT guide and training model for health workers.

It is imperative that persons coordinating, providing or establishing services are aware of, and work in accordance with the community and cultural protocols relevant to that community.

Mental health services for Indigenous people must deliver targeted and culturally responsive interventions and support developed in partnership with Aboriginal and Torres Strait Islander communities. Indigenous communities and primary health care providers must be encouraged to collaborate to develop and deliver culturally appropriate services[41].

The development of a National Mental Health Workforce Strategy under the Fourth Plan will include specific consideration of the very different pressures that may exist across rural and remote communities, and support Indigenous people to become mental health workers.

Women

International research from the National Institute for Mental Health in England shows that a high quality mental health service is one where everyone who contributes to the service is:

- knowledgeable about the ways that gender, race and other inequalities can be detrimental to mental health
- willing and able to help service users talk about their gendered lives and experiences
- alert to and challenges the ways that gender and other inequalities undermine the safety and quality of services.

All strategies developed by Governments and community services should be sensitive to the different experience of mental illness for women and men.

Proposal 12:

[41] Calma, Tom. *Creating futures; influencing the social determinates of mental health and wellbeing in rural, Indigenous and Island peoples*, in The Royal Australian and New Zealand College of Psychiatrists Journal, 2007.

Gender analysis should be applied in the development and evaluation of policy and programs to ensure gender equality in access and outcomes.

People from culturally and linguistically diverse (CALD) backgrounds

Strategies to enhance the participation of people from CALD backgrounds with mental illness in enhancing access and participation in education, training and employment initiatives must incorporate outreach and culturally tailored approaches which utilise proven models in the multicultural sector such as bilingual workers to overcome language and cultural barriers to participation. This may include partnerships with existing multicultural employment and training programs within multicultural non government organisations.

Culturally responsive strategies are informed by culturally appropriate practice. This is usually achieved when input is sought from cultural informants or bilingual workers from the cultural groups being targeted. This necessitates partnerships with transcultural mental health centres and/or multicultural sector groups.

People exiting correctional facilities

Within a custodial setting, a range of vocational, educational and employment programs are available to prisoners to assist them with gaining employment upon their release. Referrals to these courses are individualised for each prisoner, based on their areas of interest and assessed needs.

The Integrated Transitional Support Model is delivered at all secure correctional centres in Queensland. The model provides a framework for proactive release preparation planning and support to prisoners prior to their release from custody, which includes a high proportion of participants with mental health issues, due to the significant concentration and over-representation of this group in corrections.

The Transition from Correctional Facilities (TFCF) initiative is another Queensland Government initiative designed to match up housing and support for some offenders exiting correctional facilities who have been diagnosed with a moderate to severe mental illness by the Prison Mental Health Service and referred to a support provider to assist them to transition into the community for up to six months after release.

In the community, probation and parole services support offenders in relation to employment, education and training, by referring offenders to agencies that may assist them in increasing their employability skills. These referrals are individualised based on need. Once a referral is made, probation and parole regularly liaise with the referral agency to monitor the individual's progress with gaining employment or completion of programs.

If an offender is employed, probation and parole services monitor the stability of the employment through discussions with the offender and by liaising with the offender's employer as necessary.

Section Three: Strategies to Improve Capacity of Individuals, Families, Community Members, Co-Workers and Employers to Respond to the Needs of People with Mental illness

Social participation, supportive relationships, involvement in group and community activity and networks are recognised as protective factors in maintaining good mental health. Many of us obtain these through our work. Further, these can operate as early intervention strategies to prevent worsening of mental illness however it is

important to note that work is not always a protective factor. There is compelling evidence to show that workplace stress contributes significantly to the burden of mental illness[42].

Approximately 7.7 million Australians spend one-quarter to one-third of their waking lives at work so it is not surprising that we are seeing workplace stress emerging as a major cause of physical and mental health problems. The impacts differ between blue collar and white collar, men and women, and older and younger workers, with those employed in jobs which offer a low degree of control over one's work, combined with high expectations of output suffering the most job-related stress.

Strategies are required to promote healthy workplaces, and ensure that work is supports good mental health.

3.1 Community, school and workplace strategies

Improved mental illness education for employers and the workplace

Employment programs can provide a range of pre-employment skills, work readiness, case management and life skills – which help an individual reach the point where employment is an option. It is often at this point that the employment programs are unable to provide the next step, where intensive ongoing support is required. Working with employers to sustain employment is critical.

The Queensland Government is pleased to see that greater support for employers will be provided through the Job Access program, as announced in the 2011 – 2012 budget. Ideally, this support will include practical strategies as to how to manage and prevent mental illness in the workplace.

Education and information campaigns are important in reducing stigma and negative perceptions that prevent employers from providing employment opportunities to people with a mental illness. This has the added benefit of creating an atmosphere of safe disclosure, building a trust relationship between employers and employees in which the employee feels free to voice their issues and employer/employee can collaboratively address issues as they arise.

Education on mental illness, its symptoms and treatments is vital in order to reduce stigma and therefore assist in improving access for, and involvement of people experiencing mental illness. Mental Illness Education Qld (MIEQ), Mental Health First Aid (MHFA) and other similar programs can be delivered to employment agencies, education providers, workplaces and other community agencies that are accessed by this population. Employee Assistance Services and workplace rehabilitation programs can also support employees at work, or returning to work. The evidence suggests that a systems approach to promoting healthy workplaces is most likely to effect positive changes for both individuals and for workplaces (and healthier workplaces may be a preventative factor) [43].

To increase the capacity of workplaces, both the employee and the employer are likely to require ongoing support post-placement. This may include mediation; counselling (personal or together); help to address absenteeism; development of solutions including adjustments to work practices such as flexible work arrangements. This could be part of a workplace rehabilitation program. This

[42] LaMontagne AD, Shaw A, Ostry A, Louie AM, Keegel TG 2006, *Workplace Stress in Victoria - Developing a Systems Approach: Full Report* Victorian Health Promotion Foundation, Melbourne (152 pages).
[43] LaMontagne et al *ibid*

support could also be used to meet the needs of co-workers to build support and understanding in the workplace.

The Work Outcomes Research Cost-Benefit (WORC) project based at the Queensland Centre for Mental Health Research under the management of Professor Harvey Whiteford and Dr Michael Hilton has noted significant positive outcomes following early intervention and treatment for employees. For further information on the research see http://www.qcmhr.uq.edu.au/worc/projectteam.htm

Some existing models for educating employers are outlined in Appendix 1.

Proposal 13:
The Australian Government develop an education campaign, in consultation with states and territories, that provides education and practical support for employers, including education on employer and employee rights and responsibilities in respect of mental illness.

Support for education providers

In Queensland, schools establish appropriate systems and processes within the school to identify and support students with mental health difficulties. This is achieved by working collaboratively with other agencies and service providers to support families, build social networks, promote mental health awareness; and provide safe, supportive and disciplined school environments.

Improved communication and referral pathways between the mental health system and educational facilities and employers is helpful in terms of increasing awareness, providing information on early signs of ill health allowing monitoring and early intervention strategies. The Queensland EdLinq initiative provides education and health staff support to work together to enhance early identification and treatment of emerging mental health issues in school-aged children and young people.

TAFE Queensland has developed '*Reasonable Adjustment in teaching, learning and assessment for learners with a disability: A guide for VET practitioners*' to provide teachers, trainers, disability practitioners and educational managers information and practical strategies for applying reasonable adjustment in teaching, learning and assessment. A number of Professional Development activities have been undertaken to facilitate this.

TAFE Queensland Disability Support Officers also:

- offer confidential assistance when discussing a student's situation and support needs
- work with career counsellors who assist students to decide on what career path to follow and select the right program or course to achieve this career goal
- assist students to achieve their training goals
- encourage students to be independent and take responsibility for their course of study.

For students with mental illness who choose to disclose, each TAFE Queensland institute has a Disability Support Officer (or equivalent) who coordinates services to meet the student's learning needs and, if required, liaises with relevant external agencies, organisations and/or government departments.

Medicare Locals
Medicare Locals have a key role to play in terms of awareness raising and ensuring service coordination around people with mental illness. Medicare Locals should be required to ensure that they meaningfully engage with the broad range of services that relate to the determinants of health outcomes, including employment, education and training, and housing services, within their localities. Through this focus they can achieve their objectives around both population health and individual health outcomes.

Natural disaster recovery
The Queensland Government's *Queensland Mental Health Natural Disaster Recovery Plan 2011-2013* (the Recovery Plan) has been developed to promote the recovery of communities and individuals impacted by the summer 2010-2011 floods and severe weather events.

The Australian Government, through the Department of Families, Housing, Community Services and Indigenous Affairs and the Department of Health and Ageing, have contributed to the development of the Recovery Plan. Given the increasing likelihood of extreme weather events, the Australian Government may wish to consider adopting a national Mental Health Disaster Recovery Plan that complements those developed to date by some states and territories.

3.2 Specialist system strategies

Increase capacity of service providers
One of the most significant barriers for people with any sort of disability seeking, retaining and maintaining employment was employer attitudes, ranging from entrenched discrimination to misconceptions[44]. The Australian Social Inclusion Board suggests that employers need to be educated on the employment potential of disabled people and their carers and of the need for/options for flexible arrangements. The Australian Government could consider supporting training and education around responsibilities of employers around reasonable adjustments; and improve employer incentives.

Disability Employment Services
As with all employment support services for people with a mental illness, DESs need to be aware that people with a severe mental illness may not have had any social or economic inclusion for some time. A staged approach, perhaps commencing with social inclusion activities, might be an appropriate prelude to employment activity. Improved collaboration with providers of other services to people with a mental illness would help to ensure this can occur in a coordinated manner. Previous proposals contained in this submission address the need for greater awareness of mental health issues within the income support and employment support service systems.

3.3 Individual, carer and family strategies

Improve support to build capacity in carers and families
Providing strengths-based training within an individual's recovery plan would assist in building their ability to participate in education, training or employment. In addition, families and the wider community could gain an increased awareness of how to best

[44] Shut Out – report of consultation on National Disability Strategy, 2009

respond to the needs of people with mental illness by undertaking mental health first aid (MHFA) training.

Proposal 14:
Consideration should be given to national accreditation bodies including mental health first aid within other first aid courses in both the workplace and the general community.

Income Support
Some activities that the Australian Government could consider to assist individuals with a mental illness to be able to better cope when their income level drops due to the unpredictable nature of their condition include:

- Provide investment help and advice for people with a mental illness;
- A tax rebate for people with an illness or disability to allow for saving;
- Centrelink waiting periods to be more flexible;
- Create a social insurance fund that is easily accessible should an individual have to take time away from employment; and
- Centrelink and vocational rehabilitation services to have more flexible access guidelines.

Increasing the number of people with mental illness working in the field of mental health or other health related fields.
This strategy would not only provide meaningful employment to individuals, but aims to strengthen the mental health and other social and economic systems. The intent is that improved diversity leads to greater understanding of needs of different groups in the population, which improves capacity to provide services to people experiencing mental illness. Work to this end is progressing nationally through implementation of the Fourth Plan and in Queensland, also through the QPMH.

Personal support
People experiencing mental illness often identify practical access issues as a barrier to training and education. Being able to get up and get ready on time due to medication side-effects, transport to and from training or work and being able to advocate for oneself are all issues that can be overcome with assistance from a personal support worker – perhaps a consumer companion, as is the intent of Queensland's Consumer Companion program, or the national Personal Helpers and Mentors Strategy (PHaMS). The Queensland Government is pleased to see an extension of PHaMS for DSP recipients who are working with employment services, and more Support for Day to Day Living program funding, as announced in the 2011 – 2012 federal budget.

Medical treatments

The Australian Government could consider funding development of new therapies for mental illness, in particular treatments which have fewer side effects that impact on a person's ability to participate in the social and economic life of their community[45].

Further, the Pharmaceutical Benefits Scheme could increase access to evidence-based treatments for mental illness that would improve an individual's recovery from mental illness and their ability to participate in work or education.

Proposal 15:
That the Australian Government fund the research and development of treatments for mental illness which would increase a person's ability to participate in work or education, and make evidence-based pharmaceutical treatments accessible through the Pharmaceutical Benefits Scheme.

Volunteering

For some people with a severe mental illness, paid employment will never be a feasible option – nor may it be everybody's goal. Volunteering in community activities should be supported as a viable and respected occupation, and the contribution it makes to both our communities and to individual wellbeing acknowledged. Volunteering can also lead to ongoing paid employment, through the provision of vocational experience and social interactions in a work environment.

Volunteer organisations should be supported to understand the benefits of employing people who may have a mental illness. However, volunteering should not be seen as a fallback position where supporting someone into employment is considered 'too hard'. Similar support should be provided to people experiencing mental illness in volunteering arrangements, as is provided to support those in paid employment.

Proposal 16: That the Australian Government accept voluntary work as a legitimate and valued activity in the design of any new employment support programs.

[45] http://ussc.edu.au/news-room/Advances-in-medicine-for-mental-illness-have-stalled

Section Four: Queensland Government Strategic Approach to Mental Health and Employment

The Queensland Government's approach to supporting people experiencing mental illness and severe mental illness into employment acknowledges that the social and financial benefits of providing employment support, as part of a comprehensive early intervention system, far outweigh the financial costs to provide these services.[46] The cost effectiveness of early intervention and prevention programs in this context is well established.[47] The social and financial consequences of mental illness include social exclusion, loss of productivity, and costly tertiary system responses.[48]

The Queensland Government is strongly supportive of the actions which specifically address social inclusion and vocational outcomes in the Fourth Plan, and joined all states and territories in endorsing this plan at the Australian Health Ministers' Conference in November 2009. Further recognising mental health as an important area of health for Queenslanders, in February 2011 the Bligh Government established a new Mental Health Ministerial Portfolio to enhance strategic leadership in this area.

This section will detail two Queensland whole of government frameworks — Toward Q2: Tomorrow's Queensland and the Queensland Plan for Mental Health 2007-2017. Further this section also covers Queensland's commitment to the Fourth Plan. Beyond these frameworks, a range of sector-specific strategies that contribute to improving employment outcomes for people with a mental illness are also highlighted.

4.1 A whole of government and community partnership approach

The Queensland Government recognises that a whole of government, whole of community, approach is necessary to reduce the prevalence and impact of mental illness on a range of social inclusion indicators. Effective partnerships are essential to improve workforce participation for people with a mental illness. Improving collaboration between the public sector, private sector, non-government organisations, other agencies and departments and the broader community to respond to the needs of people who live with a mental illness, their families and carers is a priority for the Queensland Government. Further, promoting healthy individuals and communities through prevention and early intervention programs is central to the Government's health and community services agenda.

Responsibility for driving effective cross government and cross sector partnership for mental health in Queensland rests with the Minister for Health and the Minister for Mental Health. To facilitate this approach the Queensland Mental Health Reform Committee (QMHRC) was established in 2010 to provide a high level forum for senior representatives of state and Australian government agencies, the non-government sector, the private sector, consumers and carers. Current membership includes key stakeholders for supporting an integrated approach to increasing workforce participation among people with a mental illness among them the Queensland Department of Communities and Department of Education and Training,

[46] Mangan J and Stephen K, "Social Exclusion in Queensland: Measurement, Cost and Policy Options", Queensland Department of Employment and Industrial Relations, 2007.
[47] K. Valentine & I. Katz, "Cost Effectiveness of Early Intervention Programs for Queensland", Report prepared for the Queensland Council of Social Service Inc, 2007.
[48] G. Waghorn & C. Lloyd, "The employment of people with mental illness", *Australian e-Journal for the Advancement of Mental Health,* Vol 4, Iss 2, 2005, p32.

as well as the Commonwealth Department of Education, Employment, and Workplace Relations.

QMHRC is currently establishing a Sector Development Subcommittee which will progress the statewide implementation of the Fourth Plan's emphasis on improving vocational outcomes for mental health consumers.

The role of a recovery-oriented service system

The dominant practice framework underpinning all Queensland mental health programs is recovery. This is enshrined in the vision of the *QPMH* 'to facilitate access to a comprehensive, recovery-oriented mental health system that improves mental health for Queenslanders'.[49] Recovery is the journey toward a new and valued sense of identity, role and purpose outside the parameters of mental illness; and living well despite any limitations resulting from the illness, its treatment, and personal and environmental conditions. Vocational rehabilitation and workforce participation are central to a recovery-oriented mental health system where people experiencing mental illness are recognised as whole, equal and contributing members of our community, with the same needs and aspirations as anyone else.[50]

Queensland based research has shown that work has an important role in the recovery of people with psychiatric disabilities and many of the goals of rehabilitation are best served by addressing the person's vocational aspirations. Employment contributes to the recovery process through being perceived as a means of self-empowerment, and by promoting a sense of self-actualisation. Meaningful activities can also contribute to the recovery process, through active participation in structured social and recreational activities, volunteer work, arts, and education.[51]

The recovery approach does not focus on reduced symptoms or need for treatment alone, but on the person experiencing improved quality of life and higher levels of functioning despite their illness. Recovery acknowledges that having a mental illness does not necessarily mean life long ill health or deterioration.

The role of mainstream services

People experiencing mental illness have varying needs for support according to the severity or functional impact of their condition. Many people experiencing mental illness such as anxiety or depression do not require acute mental health services and rely on access to mainstream services. Access to mainstream services plays an important role for people experiencing mental illness to find and maintain employment.

The current approach to employment programs in Queensland is to move away from directly targeting people with a mental illness. Based on state and national priorities and the needs of communities in Queensland, mainstream employment programs target youth, Indigenous and jobless households. However, mental illness is a significant issue for many individuals in these population groups. The use of flexible case management models to support these individuals uses expertise in the community and builds customised support. It addresses the needs of people experiencing mental illness and supports their return to the labour force. This approach is supported by a recent Queensland study into the measurement and costs of social exclusion. This research found that labour market and training

[49] Queensland Government, *The Queensland Plan for Mental Health 2007-2017*, Queensland Government, Brisbane, 2008
[50] Sharing Responsibility for Recovery: creating and sustaining recovery-oriented systems of care for mental health. Queensland Health, 2005
[51] G. Waghorn & C. Lloyd, 2005, p32.

programs need to change emphasis from the single issue policies to an approach based on a significant component of case management. [52]

The role of specialised services

For people with more severe functional impairment, including those experiencing affective disorders, psychosis or schizophrenia more intensive and specialised support is required. The Queensland Government recognises this and is delivering a range of programs in specialist mental health service settings (See Appendix 1). For example, the Queensland Health Employment Specialist Initiative delivered in partnership with Disability Employment Services targets mental health consumers in specialised public mental health settings.

4.2 Queensland Government Frameworks

Toward Q2: Tomorrow's Queensland

Toward Q2: Tomorrow's Queensland (Q2) outlines the Queensland Government's vision for a strong, green, smart, healthy and fair Queensland. Q2 outlines five ambitions — Strong, Green, Smart, Healthy, Fair — and 10 long-term, measurable targets that will support progress towards this vision. Three Q2 targets in particular are relevant to improving workforce participation for people with a mental illness. These are identified below.

Smart Target: Three out of four Queenslanders will hold trade, training or tertiary qualifications

Q2 recognises that the more education people have the more they will be able to seize new opportunities, master new technologies and adapt to changing job needs. This in turn creates a strong economy with associated community wellbeing. Increasing the proportion of people aged 25–64 with a Certificate III or higher qualification to 75 per cent by 2020 represents an increase from 1.1 million Queenslanders with post school qualifications in 2008 to 2.1 million in 2020. Activities undertaken within the education and employment sectors in Queensland, described in detail in this submission and including Skilling Queenslanders for Work (SQW), ensure that mental illness is considered when determining an individual's support requirements to participate in education, training and employment.

Fair Target: Halve the proportion of Queensland children living in households without a working parent

Children who grow up in homes without a working parent are at a greater risk of experiencing unemployment and poverty themselves; and children of parents with a mental illness are at an increased risk of experiencing mental illness themselves. These risks are multiplied where children of jobless households have a parent with a mental illness. These children are more likely to perform poorly at school, be welfare dependent or work in low-income jobs, have contact with the criminal justice system and be teenage parents. To give families the best chance at success in the future and improve workforce participation in the long term, the Queensland Government is focused on helping jobless parents back into the workforce. For children of a parent with a mental illness, vocational rehabilitation of that parent will contribute to their overall recovery and reduce the additional demands on these children and young people who are also often primary carers. These additional demands impact on the ability of carers to access and maintain education, training and employment.

[52] Mangan J and Stephen K, Social Exclusion in Queensland: Measurement, Cost and Policy Options, 2007.

Fair Target: Increase by 50 per cent the proportion of Queenslanders involved in their communities as volunteers

The Queensland Government recognises the enormous contribution that volunteers make to the cultural, social and economic life of our state. Volunteering underpins strong and vibrant communities and provides important opportunities for all people to build vocational skills and connect with others. Increasing our rate of volunteering will help build stronger, more connected and caring communities – with resulting better mental health at the community and individual level.

In 2006, 37.8 per cent of Queenslanders participated in volunteer work. This is higher than the national average and is the second highest rate in Australia. Volunteer work is a valued activity in our communities in itself, and can be a pathway to employment and training for volunteers. It can be a particularly valuable social inclusion activity for people with mental illness as they progress towards education, training and employment – or, as an end in itself.

The *Queensland Plan for Mental Health 2007 – 2017*.
Under the QPMH the Queensland Government is committed to increasing vocational rehabilitation for people experiencing mental illness, and improve access to education, training and employment opportunities by 2017. A recent report on the implementation progress of the QPMH has shown it is on track to meet these outcomes. A strategy has been developed for Queensland Health investment in high priority public sector projects over the next four years of the QPMH's implementation.

The QPMH identifies five priority areas for action. These are:
- Promotion, prevention and early intervention
- Improving and integrating the care system
- Participation in the community
- Coordinating care
- Workforce, information, quality and safety.

Within these priority areas, the QPMH identifies a comprehensive range of outcomes to be achieved. All activities will improve the services available to people with a mental illness, and thereby provide opportunities to improve their capacity to participate in the workforce. Specific initiatives to improve the engagement of people with a mental illness in vocational rehabilitation and employment include:

- the development and implementation of the Queensland Health Employment Specialist Initiative which collocates an employment specialist within a mental health service;
- initiatives to foster the increased involvement of people with a mental illness in training, educational and employment readiness opportunities; and
- collaboration with the non-government sector to deliver a range of consumer-run vocational rehabilitation programs.

As Queensland's comprehensive blueprint for reform of mental health services, the QPMH acknowledges that mental health is not solely the responsibility of the health sector. Other sectors, in particular employment, housing, and disability play important roles in an individual's mental health and wellbeing, and on the broader social health of the community. Each of these sectors together with education and training, child safety, police and emergency services, corrections and justice and community

services, have a role in maximising the mental health of Queenslanders, which in turn supports meaningful participation in the workforce.

Queensland Mental Health Disaster Recovery Plan
The *Queensland Mental Health Natural Disaster Recovery Plan 2011-2013* (the Recovery Plan) recognises that natural disasters can impact adversely on social and emotional wellbeing, and will guide efforts to promote the recovery of communities and individuals impacted by the summer 2010-2011 floods and severe weather events. The Recovery Plan adopts a community development approach, building community cohesion and connectedness and enhancing the capacity of each community to support and promote its own members' recovery, resilience and access to formal services and interventions as required. Relevant activities to be undertaken under the Recovery Plan include the delivery of community education and training, the skilling community leaders and the establishment of a Community Recovery Fund to direct National Disaster Relief and Recovery Arrangements funding to appropriate community development projects.

Carer Recognition Strategy
Carers of people with mental illness can find their ability to participate in education, employment and training is reduced due to their caring commitments. They can also experience stress-related mental illness themselves. This group should be considered in the development of any strategies to support people with mental illness into workforce participation.

Through the Office for Carers the Queensland Government is working to support carers of people with a disability or mental illness.

The *Carers (Recognition) Act 2008* —includes a Carers Charter, setting out 13 principles about recognition and support for carers. All Queensland Government departments and statutory agencies must ensure awareness and implementation of the charter in their service delivery and employment practices. They also have to report on how they are doing this in their annual reports.

The Queensland Government is working with the Australian Government in the development of a National Carers Strategy. This Strategy will reflect the current planning being undertaken around three key areas - recognition and respect for carers; support for carers; and participation of carers.

Sector specific strategies
A number of sector specific policies and frameworks also aim to enhance outcomes for people with a mental illness including:

- The Queensland Department of Education and Training's Supporting Students' Mental Health and Wellbeing framework covering:
  - mental health promotion and illness prevention;
  - early intervention;
  - environment and curriculum activities that support the development of students' social and emotional skills and wellbeing; and
  - educational adjustments when mental illness prevents students from engaging appropriately.

- The Queensland Framework for Primary Mental Health Care which aims to encourage re-engineering of the primary mental health care system, with features of the ideal system including:

  - better use and coordination of available services;
  - greater consistency between services; and
  - increased awareness of mental health across the primary care system.

- The Community Mental Health Workforce Strategy is a joint initiative of the Health and Community Services Workforce Council (Workforce Council) and the Queensland Alliance, funded by DET. The Strategy aims to support the growth of a highly competent, respected and sustainable Community Mental Health workforce to meet the needs of Queensland communities into the future. The project will complement existing workforce initiatives implemented under the Queensland Compact and the Community Services Skilling Plan, as well as workforce programmes of the Department of Communities.

  A key aspect of the Workforce Strategy is to build partnerships between various stakeholders in the community mental health workforce. This includes service providers, government agencies, education and training providers, unions, professional associations, related sectors and communities. The Strategy will facilitate sector-wide collaboration on a workforce action plan with long-term vision to:
  - build capacity within the sector to collaboratively respond to identified workforce priorities;
  - improve education and training opportunities for the sector; and
  - direct workforce growth and development at a regional level.

- The Positively Ageless — Queensland Seniors Strategy 2010 – 2020 which aims to improve health and wellbeing and promote workforce participation, independence and mobility for older Queenslanders.
- The Queensland Public Service Act 2008 identifies equal employment opportunity provisions which apply to the human resource practices of all Queensland Government agencies. One of the four target groups includes people with a psychiatric disability.
- Making Tracks – toward closing the gap in health outcomes for Indigenous Queenslanders by 2033 and the Implementation Plan 2009-10 to 2011-12. This complements the significant investment made through the COAG National Indigenous Reform Agenda. Performance measures include a focus on improving mental health services and service integration; better access to mental health treatment; more effective responses to dual diagnosis of mental health and drug or alcohol abuse; and increasing the Indigenous mental health workforce by 2017.

4.3 Other key strategic frameworks and policies

The *Fourth National Mental Health Plan*

Queensland joined all Australian states and territories in endorsing the Fourth Plan in late 2009. As a Health Ministers' plan, responsibility for driving its implementation within Queensland rests with Queensland Health. At a national level, the Fourth Plan is being driven by the Australian Health Ministers' Advisory Council's Mental Health Standing Committee (MHSC). Queensland has demonstrated leadership in the development and continued implementation of the Fourth Plan through chairing the MHSC.

The Fourth Plan recognises social inclusion and recovery as one of its five priority areas. Within this priority area, key actions include:

- coordination of health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs; and
- implementation of a sustained and comprehensive national stigma reduction strategy.

The Fourth Plan acknowledges the strong evidence base, including the work of the Queensland Centre for Mental Health Research, which shows that for people with mental illness, remaining or returning to employment can be improved through the introduction of vocational support that is closely linked to treatment service delivery and support in other areas of life. Reflecting the Queensland approach, the Fourth Plan suggests mental health services can play a significant role in supporting closer engagement with employment and education sectors. For example, they can promote and facilitate the placement of Commonwealth funded Disability Employment Service providers within clinical and community support services.

During the first twelve months of the Fourth Plan, implementation activity has commenced which is within the scope of existing resources and national committees. For example, all jurisdictions have endorsed the revised National Standards for Mental Health Services and are committed to promoting their cross-sector implementation. The MHSC has also provided significant advice to Health Ministers regarding future resourcing implications of implementing the Fourth Plan, including a priority focus on the social inclusion and recovery areas of the Fourth Plan which should inform the current Inquiry.

National Mental Health Standards and National Mental Health and Disability Employment Strategy

The Queensland Government's approach to improving employment outcomes for people with mental illness is influenced by a number of other key strategies and frameworks. At a national level, the renewed National Mental Health Standards 2010 have a much greater focus on the needs of consumers and carers and include a Recovery Standard and six key National Recovery Principles. The Queensland Government has made a commitment to the revised National Standards and will support their cross sector implementation in Queensland. Policy makers at the state level are also mindful of the work being progressed by the Australian Government under the National Mental Health and Disability Employment Strategy which aims to address barriers to employment faced by people living with disability, including mental illness.

National Partnership Agreement on Homelessness

The National Partnership Agreement on Homelessness has allocated funding over five years to 2013 for several initiatives to assist people with mental illness to access sustainable housing and provide needed supports. These include:

- Young Persons Time Out House services in Cairns and Logan;
- Homeless Health Outreach Teams, which provide assertive outreach and general assistance and housing referral for people experiencing homelessness and mental health or other health concerns;
- The Post Care Support program provides support to young people with a disability who are exiting the care of the state to community-based living and independent adult life;

- The Resident Recovery Program provides support for adults who are 18 years and over, who are about to be discharged from an inpatient mental health care facility to boarding house or hostel accommodation; and
- Housing and Support Program (HASP) assists people with a psychiatric disability to live in social housing in the community. An evaluation report in 2010 found HASP to be an effective model for client recovery in a community setting, with significant cost savings compared with clinical care settings. Funding for the program was completed in 2010 – 2011.

APPENDIX 1: Some current Queensland activities in detail

The following provides a snapshot of some activities currently undertaken by the Queensland Government to enhance access to and participation in education, training and employment of people with mental illness.

The Queensland Health Employment Specialist Initiative
The aim of the Queensland Health Employment Specialist Initiative (Employment Specialist Initiative) is to improve employment outcomes for consumers with a mental illness in the public mental health system. The initiative collocates an employment consultant from a local Disability Employment Service (DES), funded by the Australian Government, within a public community mental health team to work collaboratively with consumers in helping to find work in the competitive employment market. The Employment Specialist Initiative uses the Evidence Based Supported Employment model which is based on the following principles**:**

- eligibility is based on consumer choice;
- supported employment is integrated with treatment;
- competitive employment is the goal;
- rapid job search;
- job finding and assistance is individualised;
- follow-along supports are continuous; and
- financial planning is provided.

The purpose of the initiative is to support consumers to gain employment or participate in vocational rehabilitation activities. The initiative supports clinical and functional recovery, inclusion in the wider community, and has a positive effect on the attitudes and beliefs of clinical staff regarding employment services, their own roles in the mental health service and their expectations of consumer's vocational successes. Collocating an employment consultant from the local DES within the community mental health team offers opportunities to:

- share resources;
- form common and normalising perceptions of consumers as job seekers;
- synchronise employment with health; and
- coordinate roles among team members enabling the employment consultant to focus on achieving vocational outcomes with consumers.

The initiative has been piloted in eight demonstration sites with preliminary research indicating successful consumer outcomes including personal and health benefits for consumers such as:

- increased independence, self esteem and confidence;
- increased sense of empowerment and control in life;
- increased work skills and career opportunities;
- the development of new friendships; and
- greater connectedness to the community.

Skilling Queenslanders for Work
The Queensland Government, through the Skilling Queenslanders for Work (SQW) initiative provides employment assistance to a range of individuals disadvantaged in

the labour market. SQW provides customised employment and training assistance that meets their individual needs as well as the needs of the labour market. Principles of flexible and tailored assistance apply also to the delivery of the specific employment assistance. Queensland Government programs are developed in such a way that a range of assistance tools are made available to individual participants and can be used depending on need. Each of the tools addresses vocational barriers to work and include:

- Paid work placements which provide participants with recent work history;
- Job preparation assistance to address a lack of experience in the labour market and in applying for jobs;
- Accredited training and recognition of prior learning to increase skill levels;
- Language, literacy and numeracy training; and
- Mentoring and post placement assistance to support sustainability of employment outcomes.

Assistance under SQW includes the provision of up to 6 months post placement support. Funded organisations undertake to continue to support participants for 6 months following their participation on a SQW program.
SQW assists over 24,000 individuals each year. Of those assisted, 66 per cent are in employment or training 12 months after receiving assistance.

Participate in Prosperity Program

The Participate in Prosperity (PiP) program is an element of SQW that focuses on those that are highly disadvantaged and outside of the labour market. The program funds organisations to enable highly vulnerable Queenslanders to more easily navigate and access services they may need to overcome personal difficulties, develop life skills and ultimately enter the workforce. It offers long-term individual case management to help people who struggle to meet basic needs such as financial, health and housing. PiP is achieving strong employment outcomes despite this not being the primary objective; with 43.2 per cent in work and/or training 12 months after receiving assistance.

Part of the PiP model is the provision of discretionary funds that are provided for each participant and can be used for the purchase of services or items required to assist the participant in their transition to the labour market. It can include: transport costs, childcare, items necessary to undertake an employment program, clothing, work equipment (basic items such as bags etc), immediate health care eg counselling, immediate housing issues, training and skills, utilities and basic food and emergency relief.

In addition to providing assistance to individuals, PiP also aims to generate systemic changes by linking human services to provide holistic wrap around care and build linkages across service providers in a ‘place based’ approach.

As outlined in the body of the paper, the delivery of employment programs in Queensland through Skilling Queenslanders for Work has highlighted two ‘model’ approaches that have been undertaken to support individuals with a mental illness. Examples of each model are provided below. Both models look to integrate employment and specialist support services ensuring that assistance is flexible and tailored for individual needs. These are:

1) Specialist Support – under this model, a mainstream employment project is embedded within a specialist mental health organisation. This ensures that

assistance meets the specific needs of individuals with mental health issues but is also clearly focussed on employment outcomes as a result of the assistance. Under this approach participation on the project is targeted specifically at people with a mental illness.

2) Integrated Case Management - offers long-term individual case management that provides individuals with the support they need to address their personal barriers to employment. This support is not always provided in-house, but involves accessing specialist advice and services including mental health services. The use of formal multi-agency teams brings together service providers in a local environment to streamline referrals. This approach does not target individuals with a mental illness, but looks to target individuals with a range of barriers as it provides the flexibility to meet the range of individual needs.

CASE STUDY 1 – Specialist Support

A Skilling Queenslanders for Work employment project is approved for a specialist mental health agency. The project focuses on the provision of specialist employment services but is embedded in specialist mental health services and is therefore able to meet the specific needs of this group.

The model developed will allow for a greater level of flexibility both geographically, in the nature of work placements available to participants and in the work/study mix available. Intakes by location will be staggered to enable proper coordination and supervision. In 2010-11 the following regions would benefit:

Brisbane South-Gold Coast (Gold Coast)	20
Brisbane South-Gold Coast (Logan)	20
Brisbane South-Gold Coast (Ipswich)	20
Brisbane North (Sunshine Coast/Caboolture)	20
Southern (Hervey Bay/Bundaberg)	10
North Queensland (Cairns)	10

The project is based on 205 funded places and has been allocated as 100 places for job preparation assistance; 80 places for participants undertaking significant paid work placements with host organisations and 25 places allocated for accredited training. The implementation of this project would be structured as follows:

- 4 week lead time to ensure recruitment of participants and job matching occurs together with sourcing of appropriate training;
- 15-18 week paid work placement with host employer;
- full time or part time accredited training, attended either in block training or as weekly work release linked to paid work placements;
- full time or part time training undertaken with short term non-paid work experience placements;
- between 50-100 hours of off the job training per participant;
- job search work with each participant in addition to training/work plans; and,
- 6 month follow up contact at monthly intervals with participants as required.

CASE STUDY 2 – Integrated Case Management

Funding is provided to a human services organisation to provide integrated case management to a range of individuals who are highly disadvantaged in the labour market. Implementation of a multi-agency team and use of discretionary funds provides flexibility and ensures participants are able to access the services they need.

This Participate in Prosperity project is a highly intensive case management assistance model which aims to assist these individuals and improve their ability to actively participate in the labour market. It will assist 120 people who are long term unemployed, in particular those who are at risk or are already living in poverty. The funded organisation provides a range of assistance and support to young people and families. Support provided ranges from legal advice, disability support, counselling and help finding work. Elements of the project include:

- The co-ordinator will oversee the pilot project and undertake roles such as:
    - Support the four employment Case Managers;
    - Establish and support the operations of a Multi-Agency Team;
    - Establish priority target groups for assistance in consultation with the Multi-Agency Team
    - Liaise with local industry where appropriate to identify opportunities for employment and/or relevant skills development for participants; and

- Four suitably qualified Employment Case Managers will each have a target of 30 individuals to assist over 12 months and will provide individually tailored assistance to local families/individuals with barriers to employment. This assistance will be tailored to individual need and may include:
    - Budgeting/career planning/guidance/life skills
    - Understanding the labour market
    - Linking with Australian Government funded employment agencies and Centrelink
    - Negotiating and brokering assistance from human services (eg Housing, health etc) and placements in local employment and/or training programs.
    - Continued contact with participants while other services are being provided to ensure ongoing one-on-one assistance for the individual.

- PIP Discretionary Funds - allow for the purchase of assistance and/or services for an individual that may be an impediment to seeking employment, undertaking employment/training programs or improving workforce participation.

- Logan Local Agency Panel - is the Multi-Agency Team to consider cases that require multiple agency assistance to address the barriers of individual clients, including the establishment of common support plans where appropriate. The panel consists of representatives from government departments such as Communities; Police; Education and Training; Health and Centrelink.

- Post Participation Support for all participants for up to six months to monitor their progress. Additionally, ongoing mentoring will be provided to participants until they are in stable employment.

Queensland Inclusive Social Enterprise Project

In 2009 the Queensland Department of Communities allocated a $2 million investment over two years for the establishment of up to five social enterprises in Queensland. The aim of the Queensland Inclusive Social Enterprise Project (QISEP) is to create real jobs for people with mental illness who have experienced long term unemployment. The social enterprises will provide supportive working environments that encourage people along their individual journey of recovery.

The QISEP aims to create up to 45 jobs by 30 June 2011. The non-recurrent funding is available for establishment costs to assist social enterprises to develop viable business proposals and access funding when it is timely to invest in the business.

In 2010, nine social enterprises were funded to employ people with mental illness. Social Ventures Australia (SVA) has led the implementation of QISEP by collaborating with their partners in the business sector, the non-government sector and other government departments. The corporate partners have provided expertise in market research and financial advice to emerging social enterprises that approach SVA. These social enterprises are mentored by corporate partners to develop a business case. When the business case is formalised it is presented to the SVA commerce panel for recommendations and advice on the next steps to develop the business.

BARK Indigenous Enterprises in Townsville provide an example of a recovery oriented initiative to improve workforce participation provided through QISEP. BARK provides supports for people exiting correctional facilities that experience mental illness and need assistance with housing, employment and re-connecting with family and community. SVA has supported BARK to secure local government tenders for maintenance of pipelines and parks and gardens.

The Department of Communities and SVA are now collaborating with other government departments to promote social enterprises across government procurement policies and practices.

Youth Enterprises Partnership

Youth Enterprises Partnership (YEP) has funding of $1.8 million under the prevention and early intervention initiatives under the Queensland Government Prevention and Early Intervention Incentives Pool to provide young people with skills and experience in 'real world' business ventures which increases confidence and employability. This initiative has numerous benefits for young people and their community, including:

- reduced risk factors associated with social exclusion;
- reduced involvement with criminal justice system;
- reduced homelessness and risk of homelessness;
- improved capacity to live independently;
- increased skills, capability and employability;
- increased social connectedness and re-engagement with family/community; and
- improved extent to which young people value themselves and their future.

Strategies in Queensland's Corrective Services

Queensland's Corrective Services (QCS) do not implement specific educational, vocational or training programs for offenders with mental illness. The Agency does however cater for the needs of this prisoner group through individualised referrals to broader programs including:

- Education, Vocational Education and Training (VET) — Educational, Vocational and Training courses are available in all Queensland Correctional Centres to assist prisoners with gaining qualifications to improve their employment prospects upon release to the community. Education programs available to prisoners include literacy, numeracy and secondary education. Vocational training is also available in areas such as such as construction, engineering, furnishing, hospitality and information technology.
- Advance2Work program — Advance2Work is a program delivered in all Queensland Correctional Centres that supports prisoners to become work ready and gain employment upon release. The program also provides post-release employment support to prisoners. The program is available to all prisoners who access the program six months prior to their scheduled release.
- Transitions Release Preparation Program — The Transitions Release Preparation Program for high risk and high needs offenders which is a group based program co-facilitated by local community based organisations with expertise in specific fields, including employment and training.
- Bridging the Gap pilot project — Bridging the Gap provides throughcare support for people with impaired cognitive functioning and can include services to people with co-occurring mental health issues. The service includes the delivery of specialist interventions in custody to enhance participants' communication, planning, interpersonal and conflict management skills as well as specialist case planning community reintegration support after release from custody. This is likely to address some of the potential barriers to future employment and training.
- Offender Reintegration Support Service (ORSS) — The Offender Reintegration Support Service is a service delivered by contracted non government organisations whose specialist case managers link with offenders up to nine months prior to their release and continue to support them in the community for up to six months post release. The ORSS program works to address a number of factors which may be barriers to engagement in employment and training, including: housing, budgeting, addressing addiction issues and managing health issues (including mental health issues).
- Linkages with Prison Mental Health Service — QCS link with Queensland Health through delivery of health and mental health services in Queensland prisons. Specifically, QCS works with Queensland Health and the Prison Mental Health Service to ensure offenders access appropriate mental health treatment and management, with the view to them being stabilised at the time of discharge with an appropriate treatment plan, reducing the effect of mental illness as a barrier to education, training and employment.
- Community Service Pathways Project — A Community Service Pathways project is being trialled to deliver vocational education and training to community service participants. The stated goals of the project include increasing the employability skills of offenders and assisting them with obtaining employment. Eligibility for participation requires the offender to be identified as having education and employment needs and may include offenders with mental illness. A range of vocational units are offered in a limited number of delivery sites across Queensland.

The Queensland Health Consumer Companion Program

Queensland Health's Consumer Companion Program is based on the concepts of shared experience, learning from one another and having a support from a companion. The program employs people with a lived experience of mental illness within every acute adult mental health service in Queensland to provide recovery-

focused peer support. Companions work three hour shifts and are employed as casual Queensland Health employees.

The program provides consumers with an opportunity to re-enter the workforce once they are in recovery. These roles are provided with ongoing training, supervision and support. Queensland Health employs a Consumer Companion Program Statewide Coordinator to support the companions. There are currently 85 companions employed by Queensland Health on a casual basis.

MATES in Construction

MATES in Construction (MIC) is a registered charity aimed at improving mental health and wellbeing for workers in the Queensland building and construction industry.

The MIC suicide prevention program was developed in response to the findings that construction workers are six times more likely to die from suicide than to die from an industrial accident, and that up to one in 20 construction workers will contemplate suicide during any one year. The MIC suicide prevention program provides general suicide prevention information and awareness training for construction site workers; targeted training and ongoing support for on-site 'connectors' whose role is to identify at risk workers and link them to MIC case managers and fields officers; facilitation of on-site mental health and wellbeing events; and access to a 24 hour crisis line and case management and intervention services where necessary.