From:
To: Community Affairs, Committee (SEN)
Subject: Re: Hansard corrections - Newstart and related payments inquiry - 20 November Melbourne
Date: Friday, 29 November 2019 2:37:59 PM

Dear Jeanette

Thank you for your email. I have no changes to the transcript. Attached to this email are a number of articles about IPS that I committed to sending to you. I would also direct you to the following link which is an evaluation of the DSS headspace IPS trial conducted by KPMG and released by the department yesterday.

https://t.co/ISj9X92FvC?amp=1

Kind regards

Eóin

PROFESSOR EÓIN KILLACKEY D.PSYCH (CLIN)

HEAD, FUNCTIONAL RECOVERY IN YOUTH MENTAL HEALTH

PRONOUNS: HE/HIM

35 POPLAR ROAD, PARKVILLE VIC 3052, AUSTRALIA

ORYGEN.ORG.AU

PROFESSOR OF FUNCTIONAL RECOVERY IN YOUTH MENTAL HEALTH, CENTRE FOR YOUTH MENTAL HEALTH, THE UNIVERSITY OF MELBOURNE

REVOLUTION IN MIND

Orygen acknowledges the Traditional Custodians of the lands we are on and pays respect to their Elders past and present. Orygen recognises and respects their cultural heritage, beliefs and relationships to their ancestral lands, which continue to be important to The First Nations Peoples living today.

BJPsych | The British Journal of Psychiatry (2019) 214, 76–82. doi: 10.1192/bjp.2018.191

Individual placement and support for vocational recovery in first-episode psychosis: randomised controlled trial

Eóin Killackey, Kelly Allott, Henry J. Jackson, Rosanna Scutella, Yi-Ping Tseng, Jeff Borland, Tina-Marie Proffitt, Sally Hunt, Frances Kay-Lambkin, Gina Chinnery, Gennady Baksheev, Mario Alvarez-Jimenez, Patrick D. McGorry and Susan M. Cotton

Background

High unemployment is a hallmark of psychotic illness. Individual placement and support (IPS) may be effective at assisting the vocational recoveries of young people with first-episode psychosis (FEP).

Aims

To examine the effectiveness of IPS at assisting young people with FEP to gain employment (Australian and Clinical Trials Registry ACTRN12608000094370).

Method

Young people with FEP ($n = 146$) who were interested in vocational recovery were randomised using computer-generated random permuted blocks on a 1:1 ratio to: (a) 6 months of IPS in addition to treatment as usual (TAU) or (b) TAU alone. Assessments were conducted at baseline, 6 months (end of intervention), 12 months and 18 months post-baseline by research assistants who were masked to the treatment allocations.

Results

At the end of the intervention the IPS group had a significantly higher rate of having been employed (71.2%) than the TAU group (48.0%), odds ratio 3.40 (95% CI 1.17–9.91, $Z = 2.25$, $P = 0.025$). However, this difference was not seen at 12- and 18-month follow-up points. There was no difference at any time point on educational outcomes.

Conclusions

This is the largest trial to our knowledge on the effectiveness of IPS in FEP. The IPS group achieved a very high employment rate during the 6 months of the intervention. However, the advantage of IPS was not maintained in the long term. This seems to be related more to an unusually high rate of employment being achieved in the control group rather than a gross reduction in employment among the IPS group.

Declaration of interest

None.

Keywords

First episode psychosis; vocational recovery; randomized controlled trial; psychosocial interventions.

Young people with psychotic illness, as part of their recovery, want to complete their education and gain employment more than they want to address their mental health symptoms.[1] Despite this, the vocational trajectory of young people with psychosis is marked by low educational completion rates[2] and rapid transition into unemployment.[3] Typically, the employment needs of young people with mental illnesses are referred out from mental health services to private- or government-contracted employment providers. Young people with mental ill health often have difficulty accessing these services,[4] and even where they do, employment outcomes are scandalously low.[5] The individual placement and support (IPS) model was designed to assist people with chronic severe mental illness to return to mainstream employment. IPS has been very successful,[6] even showing resilience to external economic downturns.[7] Most of the previous studies of IPS have been in populations of people with chronic illness. Two small trials[8,9] in young people with first-episode psychosis (FEP) have shown very promising results. In this paper we report on a large randomised controlled trial (RCT) of IPS in a FEP population over an 18-month follow-up period (Australian and Clinical Trials Registry ACTRN12608000094370). This allows for an examination of employment outcomes at the end of the intervention as well as the duration of effects of IPS.

Method

The background and methodology of the study has been described in detail elsewhere.[10] Key aspects of the study methodology as well as specific details concerning the participants, interventions and analyses are briefly described here. The study received ethical approval from the Melbourne Health Mental Health Research and Ethics Committee.

Trial design

This study was a parallel single-blinded RCT comparing IPS with treatment as usual (TAU) on employment and education outcomes in young people with FEP. Sample size was determined based on the results of our pilot study[9] and calculated using SamplePower 2.0. Randomisation was undertaken by the study statistician (S.M.C.) using a computer program for blocked randomisation in random permutated blocks of four and eight with an allocation ratio of 1:1. Use of permuted blocks was in order to prevent prediction of group membership before it was assigned. The statistician was not associated with assessments and treatments and was the only person aware of the allocation sequence. Group allocation was provided to the study lead who informed the employment consultant and the participant's case manager of the participant's group allocation. All effort was taken to keep research assistants masked to study condition. Research assistants had no contact with the employment consultant, and participants were reminded at the start of each assessment that they were not to let the research assistant know whether they had been working with the employment consultant or not. Recruitment occurred over a 3-year period.

Participants

Young people with FEP who had expressed an interest in vocational recovery were approached to participate. Those who agreed to

participate were required to provide written informed consent, or in the case of minors have parents/guardians provide written informed consent with the participants providing written informed assent. Participants were clients of the Early Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne, Australia. EPPIC, a component programme of Orygen Youth Health Clinical Program, is a public mental health programme that treats all young people with a FEP living in a geographically defined catchment area in the west and north-west of Melbourne. The catchment has a population of approximately one million people, with approximately 250 000 in the EPPIC age range of 15–25 years. Exclusion criteria were lack of fluency in English or an inability to consent because of acute symptomatology. There were no other exclusion criteria.

Interventions

The interventions being compared were IPS and TAU. IPS has been extensively described[11] and researched,[6] primarily in populations of people with chronic psychotic illness. IPS was delivered by a vocational specialist who had a background working in general and disability employment. In keeping with the IPS principles the vocational specialist (G.C.) was embedded as a member of the clinical team. Participants in the IPS group received 6 months of the IPS intervention.

TAU in Australia, as well as in many other similar health systems and economies, involves referral to external government-contracted employment agencies, some focused on disability employment and others on non-disabled populations of unemployed people. Apart from the referral, there is typically little follow-up between mental health and employment agencies. The burden of navigating the different systems often falls on the individual. In many countries, and particularly in Australia, people with a mental illness are able to opt out of any welfare-related obligation to seek employment via certification of a medical condition from their medical practitioner.

In addition to trial interventions, all participants continued to receive standard EPPIC treatment, including medical management and review, out-patient case management, access to EPPIC group programme and peer and family support.

Outcomes

The primary outcome of the study was employment over the first 6 months (0–6 months) of the intervention with secondary employment outcomes between 6–12 and 12–18 months post-baseline. Consistent with previous IPS literature,[9,12–14] employment was defined as working in a job that paid the legislated minimum wage for a minimum of 1 day in the previous 6-month period. Although this may not seem like much work, it should be remembered that Australian and international definitions of employment consider employment to be work for wages or other in-kind payment for a period of at least 1 hour in a specified period (for example a week).[15] Further secondary measures assessed at the 6-month intervals were duration of employment (measured in hours), educational outcome (measured in enrolment in an educational course) and receipt or not of government benefits. No measures were made of attendance at the education course, or level of academic success.

Other secondary outcomes, not reported in this paper, were symptomatology, social and economic participation, self-reported health service usage and an evaluation of the economics of the intervention.

Data analysis

Analyses were conducted using IBM SPSS Statistics Version 22 and Stata/IC 14.1 for Windows. To determine baseline demographic and clinical differences between the IPS and TAU groups, chi-square (χ^2) and independent samples *t*-tests were used. These same inferential statistics were used to test for differences on baseline and clinical variables between those who did and did not have post-randomisation and follow-up assessments (at 6, 12 and 18 months).

For the analysis of primary and secondary outcomes, a modified intent-to-treat method was used with all participants with at least one follow-up assessment post-randomisation included in the models.[16] For the analysis of the primary outcome measure of employment over 6-month intervals (0–6, 6–12 and 12–18 months, yes/no), the 'xtlogit' (random-effects model) command from Stata/IC 14.1 for Windows was used. This allows for the use of panel data accrued at different time points. In the model for the primary outcome, the core predictors were treatment group (IPS *v.* TAU), time periods (0–6, 6–12, 12–18 months), employment at baseline assessment (yes/no, a covariate) and the interaction between group and time period. The estimated probabilities for the 0–6, 6–12 and 12–18 months are reported from this model. Sensitivity analyses were conducted using models adjusted for imbalances that might be present at baseline. This approach was also used to analyse the data for the secondary outcome variables of studying status (yes/no) and dependence on government benefits (yes/no). For the analysis of the secondary outcome of hours of work, a mixed-model repeated measures was conducted using IBM SPSS Statistics Version 22.0. Within this model, the core predictors were again treatment group and time periods, and the interaction between these two variables. The Toeplitiz covariance structure was used to model the relations between observations on different occasions.

Results

Sample characteristics

There were 171 individuals assessed for eligibility to the study. Of these 171, 25 were excluded and 146 were randomised. Of the 25 that were excluded, 23 declined to participate (5 of those began baseline assessment but declined to continue) and 2 were too unwell to participate (see Supplementary Fig. 1 available at https://doi.org/10.1192/bjp.2018.191).

The majority of the cohort were male, never married, Australian born and were not studying or working at entry into the study. Most were in receipt of government benefits (Table 1). Table 2 includes details of Axis I diagnoses. The most common psychotic disorders were schizophreniform/schizophrenia, followed by bipolar disorder and schizoaffective disorder. Comorbid substance use and anxiety disorders were common in the cohort.

Representativeness

Over the 3 years of recruitment the potential pool of participants was about 800. Of this pool, approximately 50% are estimated to be unemployed based on our and others' previous work.[3,17] In this population it has been shown that 53% of people with FEP expressed a desire to find employment.[1] In our study we approached 171 people and we believe that the recruited sample was representative of the population of individuals with FEP seeking employment.

A number of the participants were in employment at baseline (IPS 21.9%, TAU 11.0%, χ^2 (1) = 3.19, $P = 0.074$). Previous Australian studies of FEP have found employment rates between 22 and 25%.[2,18] Before we commenced research in this area we conducted a survey of EPPIC clients. This found that 29% were in employment.[17] In the present study there were 16% in employment at baseline again suggesting a representative group seeking assistance through this trial.

Table 1 Baseline demographic data of the total cohort and separately for the individual placement and support (IPS) and treatment-as-usual (TAU) groups

	Total ($n = 146$)	IPS ($n = 73$)	TAU ($n = 73$)	t	χ^2	d.f.	P
Demographic							
Gender, female: % (n)	30.8 (45)	42.5 (31)	19.2 (14)	–	9.28	1	0.002
Age, mean (s.d.)	20.4 (2.4)	20.4 (2.7)	20.5 (2.1)	−0.14	–	144	0.890
Never married, % (n)	97.3 (142)	98.6 (72)	95.9 (70)	–	1.03	1	0.311
Country of birth, Australian born: % (n)	76.0 (111)	79.5 (58)	72.6 (53)	–	0.94	1	0.332
Education, % (n)							
Current study status							
Not studying	82.2 (120)	83.6 (61)	80.8 (59)	–	0.19[a]	1	0.665
Studying part time	8.2 (12)	8.2 (6)	8.2 (6)	–	–	–	–
Studying full time	9.6 (14)	8.2 (6)	11.0 (8)	–	–	–	–
Highest year of school							
Years 7–9	22.6 (33)	17.8 (13)	27.4 (20)	–	3.17	3	0.366
Year 10	18.5 (27)	21.9 (16)	15.1 (11)	–	–	–	–
Year 11	18.5 (27)	16.4 (12)	20.5 (15)	–	–	–	–
VCE/VCAL	40.4 (59)	43.8 (32)	37.0 (27)	–	–	–	–
Employment							
Age at first job, mean (s.d.)	15.7 (2.1)	15.7 (2.2)	15.7 (2.0)	0.18	–	134	0.859
Currently in paid work, % (n)	16.4 (24)	21.9 (16)	11.0 (8)	–	3.19	1	0.074
Income, % (n)							
Registered with a government agency	58.2 (85)	53.4 (39)	63.0 (46)	–	1.38	1	0.240
Receiving government payments	66.2 (96)[c]	65.8 (48)	66.7 (48)[c]	–	0.01	1	0.907
Main source of income, % (n)							
Wages, salary, own employment	13.7 (19)[d]	18.3 (13)[e]	8.8 (6)[f]	–	3.13	3	0.372
Centrelink payments[b]	64.7 (90)[d]	63.4 (45)[e]	66.2 (45)[f]	–	–	–	–
Family or friends	18.7 (26)[d]	15.5 (11)[e]	22.1 (15)[f]	–	–	–	–
Other sources	2.9 (4)[d]	2.8 (2)[e]	2.9 (2)[f]	–	–	–	–

VCE, Victorian Certificate of Education; VCAL is Victorian Certificate of Applied Learning – year 12 courses.
a. χ^2 value derived from comparison of collapsed categories (studying or not studying).
b. Centrelink is the Australian national welfare agency responsible for managing welfare payments.
c. Missing = 1
d. Missing = 7
e. Missing = 2
f. Missing = 5

Baseline characteristics

The two treatment groups differed significantly with respect to gender distribution, $\chi^2(1) = 9.28$, $P = 0.002$, with the IPS having twice the number of female participants compared with the TAU group (Table 1). There were no significant between-group differences with respect to psychotic symptoms, overall functioning and type of psychotic disorder; however, the TAU group were significantly more likely to have a substance use disorder at baseline, $\chi^2(1) = 3.99$, $P = 0.046$ (Table 2).

The IPS group was significantly more depressed, $t(143) = 2.38$, $P = 0.019$ (Table 2), had poorer psychological quality of life (QoL, $t(143) = -2.27$, $P = 0.025$) and poorer physical health QoL ($t(143) = -2.34$, $P = 0.021$) at baseline compared with the TAU group. They had also been in the EPPIC service longer (IPS 301.97 days *v.* TAU 215.99 days ($t(139) = 2.70$, $P = 0.008$)).

Participant flow

There were 95 participants who had complete employment data over the 18 months. A range of missing data patterns were observed: (a) 1 participant was missing 6-month data only; (b) 5 participants had only 12-month data missing; (c) 1 participant was missing 6- and 12-months data; (d) 3 participants had missing data for 6 and 18 months; (e) 15 participants had 12- and 18- month data missing; and (f) 11 participants were missing 18-month data only. There were 15 participants who had no data for any of the follow-up data points. Therefore, post-randomisation data was available for 131 participants.

Of those with no post-randomisation data, seven had moved out of the catchment area, two withdrew participation as a result of having employment, five withdrew consent with no reasons provided, and one withdrew consent because of lack of time. The TAU group (16.4%, $n = 12$) was more likely to have no post-randomisation data than the IPS group (4.1%, $n = 3$), $\chi^2(1) = 6.02$, $P = 0.014$.

Despite the differences in availability of post-randomisation data, there were no significant differences between the two groups with respect rates of missingness at 6 months (IPS 9.6%, $n = 7$; TAU 17.8%, $n = 13$) $\chi^2(1) = 2.09$, $P = 0.149$; at 12 months (IPS 20.5%, $n = 15$; TAU 28.8%, $n = 21$) $\chi^2(1) = 1.33$, $P = 0.249$; and at 18 months (IPS 23.3%, $n = 17$; TAU 37.0%, $n = 27$) $\chi^2(1) = 3.25$, $P = 0.071$. There were no significant differences between those with and without data at each of these three time points in terms of baseline demographics, vocational and clinical data. Analyses were also conducted to determine whether missing data at a time point depended on vocational status at the previous time point. Those who provided data at 18 months, were significantly more likely to be studying at 12 months (59.4%, $n = 57$) than those individuals who were missing data at 18 months (28.6%, $n = 4$, $\chi^2(1) = 4.69$, $P = 0.030$); however, further breakdown by treatment group was not possible because of low numbers.

IPS fidelity

As a result of resource constraints, it was not possible to engage an independent evaluator to conduct a fidelity review of our IPS intervention. However, we conducted an audit of our intervention via a self-administration of the Supported Employment Fidelity Scale.[19] This audit indicated that our intervention was in the range of good fidelity.[19]

Primary outcome – employment status

At the end of the intervention, the IPS group had a significantly higher rate of having been employed (71.2%, 47/66) than the TAU group (48%, 29/60), odds ratio (OR) = 3.40 (95% CI 1.17-9.91, z = 2.25,

Table 2 Diagnostic, clinical, functioning and quality of life (QoL) characteristics of the individual placement and support (IPS) and treatment-as-usual (TAU) groups at baseline

	Total ($n = 146$)	IPS ($n = 73$)	TAU ($n = 73$)	t	χ^2	d.f.	P
Psychotic disorder, % (*n*)							
Schizophreniform/schizophrenia	43.8 (64)	45.2 (33)	42.4 (31)	–	4.26	5	0.513
Schizoaffective disorder	13.0 (19)	11.0 (8)	15.1 (11)	–	–	–	–
Major depressive disorder, psychotic features	11.6 (17)	9.6 (7)	13.7 (10)	–	–	–	–
Bipolar disorder	13.7 (20)	12.3 (9)	15.1 (11)	–	–	–	–
Psychosis, not otherwise specified	11.6 (17)	16.4 (12)	6.8 (5)	–	–	–	–
Other	6.2 (9)	5.5 (4)	6.8 (5)	–	–	–	–
Substance use disorder, % (*n*)	29.5 (43)	21.9 (16)	37.0 (27)	–	3.99	1	0.046
Post-traumatic stress disorder, % (*n*)	13.0 (19)	15.1 (11)	11.0 (8)	–	0.55	1	0.461
Anxiety disorder, % (*n*)	32.2 (47)	37.0 (27)	27.4 (20)	–	1.54	1	0.215
Symptoms, mean (s.d.)							
Brief Psychiatric Rating Scale							
Total score	45.5 (12.0)	45.6 (11.7)	45.4 (12.4)	0.10	–	144	0.923
Positive symptoms	8.5 (4.4)	8.5 (4.4)	8.6 (4.4)	–0.19	–	144	0.851
Scale for the Assessment of Negative Symptoms							
Affective flattening or blunting	9.4 (7.2)	8.8 (7.5)	9.9 (6.9)	–0.93	–	144	0.352
Alogia	5.2 (4.1)	5.0 (4.1)	5.4 (4.2)	–0.54	–	144	0.589
Avolition	7.5 (3.7)	6.9 (3.7)	8.0 (3.7)	–1.78	–	144	0.078
Anhedonia[a]	9.3 (5.3)	9.1 (4.7)	9.5 (6.0)	–0.45	–	135.9	0.653
Attention	3.5 (3.1)	3.1 (3.0)	4.0 (3.1)	–1.81	–	143	0.073
Summary[b]	9.3 (3.9)	8.7 (3.7)	10.0 (4.1)	–1.91	–	144	0.058
Composite[c]	25.5 (12.4)	24.2 (12.1)	26.8 (12.6)	–1.27	–	144	0.206
Centre for Epidemiologic Studies of Depression Scale	19.7 (11.5)	22.2 (12.0)	17.7 (11.9)	2.38	–	143	0.019
Functioning, mean (s.d.)							
Social and Occupational Functioning Scale	51.5 (10.4)	52.1 (10.2)	50.8 (10.6)	0.73	–	144	0.465
QoL, mean (s.d.)							
Psychological	64.7 (16.1)	61.7 (16.0)	67.7 (15.8)	–2.27	–	143	0.025
Physical health	53.4 (19.6)	49.6 (18.7)	57.1 (19.8)	–2.34	–	143	0.021
Social relations	57.4 (21.9)	54.5 (21.5)	60.2 (22.2)	–1.56	–	143	0.122
Environmental	62.0 (16.0)	60.5 (16.1)	63.4 (15.8)	–1.09	–	143	0.276
Premorbid IQ, mean (s.d.)							
Wide Range Achievement Test, standard score	92.4 (13.9)	93.5 (13.7)	91.3 (14.2)	0.92	–	144	0.359

a. Degrees of freedom were adjusted for the *t*-test because of violation to the assumption of homogeneity of variance.
b. Based on the sum of the global items.
c. Based on the sum of the 20 individual items.

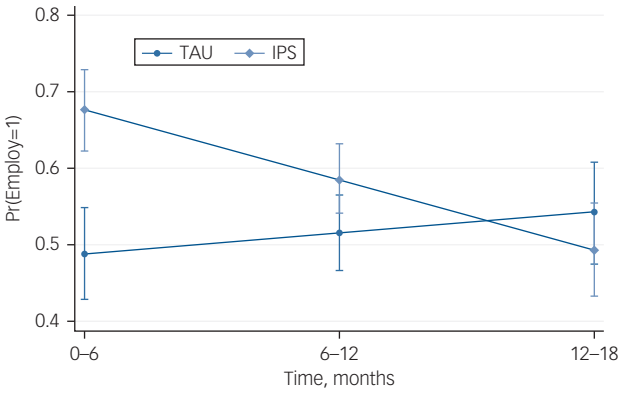

Fig. 1 Predicted probabilities (s.e.) of employment in individual placement and support (IPS) and treatment-as-usual (TAU) groups over 18 months.

$P = 0.025$). The greatest difference in the predicted probabilities of employment between the IPS and TAU groups was observed over the first 6 months, with minimal differences seen at later 6-month time intervals (Fig. 1). Within the primary random-effects logistic regression model the interaction between group and time period was significant, OR = 0.88 (95% CI 0.78–0.99, Wald $z = -2.16$, $P = 0.031$), even after controlling for baseline employment status. The odds ratio comparing employment between the IPS and TAU groups for the 0–6-month period was significant, OR = 3.40 (95% CI 1.17–9.91, $z = 2.25$, $P = 0.025$); however, no significant between-group differences in odds of employment were seen at 6–12 and 12–18 months ($P = 0.288$ and $P = 0.594$, respectively).

The percent change in estimate odds was calculated for the two groups.[20] The conditional odds of employment increased by 2.8% per 6-month time period in the TAU group whereas there was a decrease by 9.5% per 6-month period in the IPS group. An adjusted model was also run controlling for baseline employment status, gender and baseline depressive symptoms. QoL was not included in this model because of the overlap with depressive symptoms. For this adjusted model the interaction between group and time remained significant, OR = 0.88 (95% CI 0.78–0.99, Wald $z = -2.26$, $P = 0.024$). The odds ratio comparing groups at 0–6 months also remained significant, OR = 3.57 (95% CI 1.19–10.70, $z = 2.28$, $P = 0.023$) whereas group comparisons at 6–12 and 12–18 months were non-significant ($P = 0.293$ and $P = 0.576$, respectively).

Secondary outcomes – hours worked, studying and Government pensions

The average hours worked over the three time periods for the two groups is displayed in Supplementary Fig. 2. Note that information regarding hours worked in the 6-month period prior to randomisation was not collected so there were no covariates in this model. The interaction between treatment group and time was not significant, $F(2, 148.4) = 0.95$, $P = 0.390$. Furthermore, the main effects for

time, $F(2, 148.4) = 0.50$, $P = 0.608$ and for group, $F(1,112.9) = 0.20$, $P = 0.652$, were not significant.

The predicted probability of the two groups studying over the 18 months are displayed in Supplementary Fig. 3. Notably, the IPS group was more likely to be studying at each of the follow-up 6-month time intervals. There was a significant interaction between group and time with respect to studying status, OR = 0.87 (95% CI 0.77–0.97, Wald $z = -2.37$, $P = 0.018$), after controlling for baseline study status. The odds ratio comparing studying status between the IPS and TAU groups at the 0–6-month time interval was significant, OR = 3.04 (95% CI 1.01–9.17, Wald $z = 1.97$, $P = 0.049$. No between-group differences were observed at 6–12 and 12–18 months ($P = 0.584$ and $P = 0.300$, respectively). The conditional odds of studying increased by 7.6% per 6-month time period in the TAU group whereas there was a decrease by 6.9% per 6-month period in the IPS group. The model was re-run controlling for baseline studying status, gender and baseline depressive symptoms; the interaction remained significant, OR = 0.86 (95% CI 0.77–0.97, $z = -2.40$, $P = 0.016$). Controlling for these three variables; however, the point-estimate for difference between the groups in the 0–6 months interval was no longer significant ($P = 0.084$).

The interaction between group and time period for dependence on pensions was not significant, OR = 0.98 (95% CI 0.84–1.13, $z = -0.31$, $P = 0.757$), after controlling for baseline dependence on government pensions. This result remained non-significant after controlling for gender, baseline government pension status and baseline depressive symptoms.

Discussion

Key findings and comparison with findings from other studies

This is the largest trial to our knowledge on the efficacy of IPS in FEP. It is also one of the only trials in FEP to examine the duration of employment past the intervention stage. The key findings were that IPS was superior to TAU in rates of employment over 6 months, but this finding was not sustained after the intervention period at 12- and 18-month follow-up. Duration of employment and educational engagement did not differ between groups at any time point.

In previous trials of IPS in FEP populations, IPS has produced favourable employment outcomes compared with comparison conditions.[21] This finding has been replicated here, at least at the end of 6 months of intervention. However, the benefit of IPS in the present study is seen to disappear relative to the control group over the follow-up period. This contrasts with studies of IPS in populations with chronic illness in which the benefit of IPS persists over time.[7,22,23] However, the result in the present study seems to be as much about the higher than expected performance of the control group as it is about the failure of the IPS group to maintain its initial significant benefit.

In a previous, albeit smaller ($n = 41$) RCT of IPS conducted in the same clinic, the control group achieved only a 9.5% employment outcome at the end of the 6-month intervention.[9] However, in the current study the control group employment rate was 48% at the 6-month time point. In comparison, the IPS group in our initial study[9] had a 65% employment rate that is similar to the 71% achieved in the present study. This raises the question of what could account for this type of improvement in the control group results.

Possible reasons for our findings concerning the control group

We believe that there are three possible explanations for the improvement in the control group results. The first possible reason is that the external, government-contracted employment agencies that are current best practice have improved their performance in relation to facilitating the employment of young people with psychosis, but this seems unlikely. During the time period of the current study the government department responsible for employment services in Australia conducted a review of performance of the system. That review found that in relation to outcomes for people with psychiatric and psychological disabilities that the highest level of support provided only resulted in 14% of people obtaining employment lasting 13 weeks.[5] Although there was at that time also a payment for agencies that assisted people to access 26 weeks of employment, no data was reported for the percentage that made it to 26 weeks. One possible interpretation was that the number who did so was so small as to not be worth reporting. In a system that is performing so poorly at a national level it is possible but less likely that our local employment services were producing results that would be sufficiently better than the rest of the national system to explain our outcomes.

The second possible explanation of the results of the control group is speculation that there was a change in the clinical culture in relation to vocational outcomes in the EPPIC clinic where the study was conducted. As mentioned, EPPIC was also the site at which we conducted a previous RCT of IPS in FEP.[9] That first RCT was the first time that IPS had been introduced to the EPPIC clinic. Initially, when we introduced IPS there was scepticism from clinicians that young people with IPS would be able to enter or return to employment in significant proportions. However, as they witnessed the success of the young people with psychosis in that trial in returning to and successfully engaging with employment, much of their scepticism translated to enthusiasm for exploring the vocational ambitions of their clients.

Further, there was a 2-year window between the end of the first study and commencement of the second. During this time, demand for IPS services outstripped the resources that were available to supply IPS. In order to assist, a number of workshops were conducted with clinical staff about how to engage in assisting their clients to obtain employment or return to school. As a consequence, the clinical staff were upskilled around employment. Some evidence that may support this supposition comes from a file audit study of a cohort of EPPIC clients conducted before the current trial.[24] The file audit showed that at discharge from EPPIC, the majority of clients were unemployed and not studying. Further evidence of the acceptance of the possibility and importance of vocational recovery among the clinical staff and management of EPPIC was that during this time one clinical position was converted to an IPS position. In a cash-strapped public mental health service, this is a strong indication of the perceived value of an intervention. The positive impact of changed staff attitudes on employment outcomes for people with FEP has previously been demonstrated by Craig *et al*,[25] providing some tentative support for this hypothesis. Nevertheless, this possible explanation is speculative as there was no systematic measurement of clinical staff attitudes and skills in relation to vocational recovery. If there is an acceptance of the possibility that this cultural change explains elements of the results, there are a number of positive conclusions to be drawn.

Too often in the past clinicians and others involved in care have 'protected' young people with psychosis from the possible stressors that exist in pursuing vocational recovery.[3] This is a classic example, although often well motivated, of the 'soft bigotry of low expectations'. Where it leads to failure to realise educational potential, abandonment of vocational dreams, lifelong unemployment and social exclusion, this form of protection is no protection at all. It is therefore hopeful that the vocational expectations clinicians hold may be adjusted in light of new evidence. In this case, that young people with psychosis can and should obtain and retain employment.

That end-of-intervention outcomes were significantly better for IPS suggests that the expertise of a specialist IPS worker has something to offer over the skill of a mental health clinician. As IPS is still largely a research intervention in many parts of the world, there is not a ready workforce to conduct IPS in mental health services. If it is possible to upskill existing mental health workforces to address this much-desired element of recovery it may be possible to deliver a more stepped vocational recovery model. For those with better employment or educational prospects, the assistance of their mental health clinician who has done further training might be sufficient. For those with poorer vocational prognoses, or who have not achieved the vocational outcomes they sought with their mental health clinician, referral to an IPS specialist would be indicated.

Importantly, irrespective of which level of vocational intensity was accessed, our findings suggest that strategies to promote long-term maintenance of vocational functioning should be implemented. Although IPS was effective while being implemented, in common with many psychosocial interventions, the benefit of IPS in this study was reduced over time. This suggests a need to focus in future on mechanisms to extend this positive benefit, which can be scalable over time and are not excessively resource intensive. Examining the ways in which technology can be of assistance in this area may be worthwhile.[26]

A third possible explanation that is not mutually exclusive from the others is a change in government policy in relation to young people, employment, education and welfare that may have had an impact on the results of the control group. Such a change in policy did occur during the course of the study. The effect of this policy change was that to remain eligible for welfare payments, young people who had not completed high school or an equivalent had to be enrolled in an educational course of some kind. Although this may explain why there was no difference in the level of educational outcomes in the study, it does not explain the high rates of employment seen in the control group.

Implications of findings regarding educational outcomes

Given the age range of people typically attending FEP services, a focus on education as part of vocational recovery is important. However, the treatment groups did not differ on educational outcomes at any time point. This is consistent with other IPS study results[13] and indicates that IPS as currently practised may require adaptation for enhanced education outcomes. There is no reference to education in the IPS fidelity scale which in turn comes from IPS being an intervention primarily developed in adults with severe mental illness and with a sole focus on employment. In addition to this it suggests an addition education focused skill-set may be needed for IPS workers to successfully address educational vocational recovery in young people. Recent evidence tentatively suggests that adapting IPS to a specific focus on education, with an IPS worker with expertise in working in the education sector can achieve good educational outcomes.[27] However, this is an area in need of more and controlled research.

Strengths and limitations

The strengths of this study include that it was adequately powered to explore the effect of IPS on employment rates of young people with FEP. Further, only four participants did not complete the intervention, and there was low attrition across the 18 months of the study with 87% included in the final analysis. The study also reflected real-world practice in having few exclusion criteria. This is important in considering translation of IPS into routine practice in FEP services.

The study had some limitations that should be considered. It was conducted in Australia and results may be limited in their generalisability by the economic, welfare and labour market context that the study occurred within. The intervention period was only 6 months. This is short by contrast with other international IPS trials. For pragmatic reasons and based on our earlier pilot study,[9] we provided 6 months of intervention. Many other trials provide 9 or more months. It is possible that initial gains may have been better maintained with a longer intervention or top-up sessions. One way we are currently addressing this in our clinic is employing peer workers to work alongside IPS workers and to provide more support than the IPS worker alone is able to provide.

Resource limitations meant that this study had a single IPS worker rather than a team of IPS workers. This may have limited the capacity for thorough follow-along support that in turn may have had an impact on the duration of employment. Primary outcome measurement is an issue in the IPS literature with no set standard. Some studies use obtainment of employment with no measure of duration, some use a day, a week or a number of hours per week as a threshold. Our study used at least 1 day of work in the previous 6 months. It is possible that using a different definition would have led to different results. However, our definition is consistent with some IPS literature and our own previously published work in this area. Measurement of education is important in this cohort, some of whom are younger than the legal working age. There are currently few good measures of educational outcomes for people with mental illness and this is an area that requires attention. Another limitation is that there was likely to be less post-randomisation data in the TAU group. This is mitigated somewhat by there being no differences between the groups in terms of missingness, and baseline vocational, clinical and demographic data. Finally, although there was an initial benefit of IPS for education at the 6-month time point, this is seen to disappear when baseline variables are considered.

In conclusion, IPS is effective at supporting young people with FEP to return to work. However, this benefit was not maintained compared with usual treatment in a clinic in which clinical staff are optimistic about, and have been upskilled around, the provision of vocational recovery. This suggests that specialist vocational recovery services may be most usefully deployed for people who have failed to make an initial vocational recovery during their usual treatment. Further, this study along with others has not demonstrated that a general approach to vocational recovery using IPS leads to superior educational outcomes. A more specific and targeted approach to education may be needed.

Eóin Killackey, DPsych (Clin), Professor of Functional Recovery in Youth Mental Health, Orygen, The National Centre of Excellence in Youth Mental Health and Centre for Youth Mental Health, The University of Melbourne, Australia; **Kelly Allott**, PhD, Senior Research Fellow, Orygen, The National Centre of Excellence in Youth Mental Health and Centre for Youth Mental Health, The University of Melbourne, Australia; **Henry J. Jackson**, PhD, Professor, Melbourne School of Psychological Sciences, The University of Melbourne, Australia; **Rosanna Scutella**, PhD, Senior Research Fellow, Melbourne Institute, The University of Melbourne, Australia; **Yi-Ping Tseng**, PhD, Senior Research Fellow, Melbourne Institute, The University of Melbourne, Australia; **Jeff Borland**, PhD, Professor, Melbourne Institute and Department of Economics, The University of Melbourne, Australia; **Tina-Marie Proffitt**, DPsych (NeuroPsych), Research Fellow and Neuropsychologist, Orygen, The National Centre of Excellence in Youth Mental Health, Centre for Youth Mental Health, The University of Melbourne and School of Psychology, University of Waikato, Australia; **Sally Hunt**, PhD, Research Fellow, School of Medicine and Public Health, University of Newcastle, Australia; **Frances Kay-Lambkin**, PhD, Associate Professor, School of Medicine and Public Health, University of Newcastle, Australia; **Gina Chinnery**, BBus (HR), National Vocational Services Manager, Orygen, The National Centre of Excellence in Youth Mental Health, Australia; **Gennady Baksheev**, PhD, Research Assistant, Monash University, Australia; **Mario Alvarez-Jimenez**, PhD, Associate Professor, Orygen, The National Centre of Excellence in Youth Mental Health and Centre for Youth Mental Health, The University of Melbourne, Australia; **Patrick D. McGorry**, PhD, Professor, Orygen, The National Centre of Excellence in Youth Mental Health and Centre for Youth Mental Health, The University of Melbourne, Australia; **Susan M. Cotton**, PhD, Professor, Orygen, The National Centre of Excellence in Youth Mental Health and Centre for Youth Mental Health, The University of Melbourne, Australia

Correspondence: Eóin Killackey, Orygen, The National Centre of Excellence in Youth Mental Health, 35 Poplar Road, Parkville, Victoria 3052, Australia. Email: eoin@unimelb.edu.au

First received 25 May 2018, final revision 20 Jul 2018, accepted 20 Aug 2018

Funding

This work was supported by the following grants: Australian Research Council LP0883237; Australian Rotary Health Mental Health Grant, and; National Health and Medical Research Council CCRE 264611. The following fellowships were held by authors related to this project: E.K – Ronald Philip Griffith Fellowship Faculty of Medicine Dentistry and Health Sciences, The University of Melbourne; NHMRC CDF II Fellowship APP1051891; BB & A Miller Foundation Fellowship; K.A. – Ronald Philip Griffiths Fellowship Faculty of Medicine Dentistry and Health Sciences, The University of Melbourne; S.M.C. – Ronald Philip Griffith Fellowship Faculty of Medicine Dentistry and Health Sciences, The University of Melbourne; NHMRC CDF Level II Fellowship APP1061998 and NHMR Senior Research Fellowship APP1136344; M.A.-J. – CR Roper Fellowship Faculty of Medicine Dentistry and Health Sciences, The University of Melbourne; NHMRC Career Development Fellowship APP1082934; and F.K.-L. – NHMRC CDF Level I Fellowship APP1008972 and NHMRC Senior Research Fellowship APP1110371.

Acknowledgements

We wish to express our deep appreciation for all the participants of this trial who contributed their time and lived experience to our research. The authors acknowledge the dedication and hard work of the research assistants who worked on this trial, and the EPPIC Clinical programme for facilitating this research.

Supplementary material

Supplementary material is available online at https://doi.org/10.1192/bjp.2018.191

References

1 Ramsay CE, Broussard B, Goulding SM, Cristofaro S, Hall D, Kaslow NJ, et al. Life and treatment goals of individuals hospitalized for first-episode nonaffective psychosis. *Psychiatry Res* 2011; **189**: 344–8.

2 Waghorn G, Saha S, Harvey C, Morgan VA, Waterreus A, Bush R, et al. 'Earning and learning' in those with psychotic disorders: the second Australian national survey of psychosis. *Aust N Z J Psychiatry* 2012; **46**: 774–85.

3 Rinaldi M, Killackey E, Smith J, Shepherd G, Singh SP, Craig T. First episode psychosis and employment: a review. *Int Rev Psychiatry* 2010; **22**: 148–62.

4 Scott J, Fowler D, McGorry P, Birchwood M, Killackey E, Christensen H, et al. Adolescents and young adults who are not in employment, education, or training. *BMJ* 2013; **347**: f5270.

5 Department of Education, Employment and Workplace Relations. *Evaluation of Disability Employment Services Interim Report, Reissue March 2012*. Australian Government, 2012.

6 Bond G. *Evidence for the Effectiveness of the Individual Placement and Support Model of Supported Employment*. IPS Works, 2018 (https://ipsworks.org/index.php/evidence-for-ips/).

7 Modini M, Tan L, Brinchmann B, Wang M-J, Killackey E, Glozier N, et al. The effectiveness of supported employment vocational programs for people with severe mental illness: a systematic review and meta-analysis of the international literature. *Br J Psychiatry* 2016; **209**: 14–22.

8 Nuechterlein KH, Subotnik KL, Turner LR, Ventura J, Becker DR, Drake RE. Individual placement and support for individuals with recent-onset schizophrenia: integrating supported education and supported employment. *Psychiatr Rehabil J* 2008; **31**: 340–9.

9 Killackey E, Jackson HJ, McGorry PD. Vocational intervention in first-episode psychosis: individual placement and support v. treatment as usual. *Br J Psychiatry* 2008; **193**: 114–20.

10 Killackey E, Allott K, Cotton SM, Jackson H, Scutella R, Tseng YP, et al. A randomized controlled trial of vocational intervention for young people with first-episode psychosis: method. *Early Interv Psychiatry* 2013; **7**: 329–37.

11 Drake R, Bond G, Becker D. *Individual Placement and Support: An Evidence-Based Approach to Supported Employment (Evidence-Based Practice)*. Oxford University Press, 2012.

12 Bejerholm U, Areberg C, Hofgren C, Sandlund M, Rinaldi M. Individual placement and support in Sweden - a randomized controlled trial. *Nord J Psychiatry* 2015; **69**: 57–66.

13 Bond GR, Drake RE, Campbell K. Effectiveness of individual placement and support supported employment for young adults. *Early Interv Psychiatry* 2014; 300–710.

14 Oshima I, Sono T, Bond GR, Nishio M, Ito J. A randomized controlled trial of individual placement and support in Japan. *Psychiatr Rehabil J* 2014; **37**: 137–43.

15 Australian Bureau of Statistics. *Labour Statistics: Concepts, Sources and Methods*. Australian Bureau of Statistics, 2006. (http://www.abs.gov.au/Ausstats/abs@.nsf/2f762f95845417aeca25706c00834efa/47bfb611a97c91f2ca25710e007321c6!OpenDocument").

16 Polit DF, Gillespie BM. Intention-to-treat in randomized controlled trials: recommendations for a total trial strategy. *Res Nurs Health* 2010; **33**: 335–68.

17 Killackey EJ, Jackson HJ, Gleeson J, Hickie IB, McGorry PD. Exciting career opportunity beckons! Early intervention and vocational rehabilitation in first-episode psychosis: employing cautious optimism. *Aust N Z J Psychiatry* 2006; **40**: 951–62.

18 Cotton SM, Lambert M, Schimmelmann BG, Filia K, Rayner V, Hides L, et al. Predictors of functional status at service entry and discharge among young people with first episode psychosis. *Soc Psychiatry Psychiatr Epidemiol* 2017; **52**: 575–85.

19 IPS Works. *Supported Employment Fidelity Scale*. IPS Works, 2008 (https://ipsworks.org/wp-content/uploads/2017/08/IPS-Fidelity-Scale-Eng1.pdf).

20 Rabe-Hesketh S, Skrondal A. *Multilevel and Longitudinal Modelling Using Stata*. StataCorp LP, 2008.

21 Bond GR, Drake RE, Luciano A. Employment and educational outcomes in early intervention programmes for early psychosis: a systematic review. *Epidemiol Psychiatr Sci* 2015; **24**: 446–57.

22 Drake RE, Bond GR, Becker DR. *IPS Supported Employment: An Evidence Based Approach to Supported Employment*. Oxford University Press, 2012.

23 Hoffmann H, Jäckel D, Glauser S, Mueser KT, Kupper Z. Long-term effectiveness of supported employment: 5-year follow-up of a randomized controlled trial. *Am J Psychiatry* 2014; **171**: 1183–90.

24 Cotton SM, Lambert M, Schimmelmann BG, Filia K, Rayner V, Hides L, et al. Predictors of functional status at service entry and discharge among young people with first episode psychosis. *Soc Psychiatry Psychiatr Epidemiol* 2017; **52**: 575–85.

25 Craig T, Shepherd G, Rinaldi M, Smith J, Carr S, Preston F, et al. Vocational rehabilitation in early psychosis: cluster randomised trial. *Br J Psychiatry* 2014; **205**: 145–50.

26 Alvarez-Jimenez M, Bendall S, Lederman R, Wadley G, Chinnery G, Vargas S, et al. On the HORYZON: moderated online social therapy for long-term recovery in first episode psychosis. *Schizophr Res* 2013; **143**: 143–9.

27 Killackey E, Allott K, Woodhead G, Connor S, Dragon S, Ring J. Individual placement and support supported education in early stage mental illness: an exploratory study. *Early Interv Psychiatry* 2017; **11**: 526–31.

EXTRA CONTENT ONLINE

Early Intervention IN PSYCHIATRY
First Impact Factor released in June 2010 and now listed in MEDLINE!
International Early Psychosis Association

Early Intervention in Psychiatry 2016; ••: ••–••
doi: 10.1111/eip.12344

Early Intervention in the Real World

Individual placement and support, supported education in young people with mental illness: an exploratory feasibility study

Eóin Killackey,[1,2] Kelly Allott,[1,2] Gina Woodhead,[3] Sue Connor,[3,4] Susan Dragon[1] and Judy Ring[3,4]

[1] Orygen — The National Centre for Excellence in Youth Mental Health, [2] Centre for Youth Mental Health, The University of Melbourne, [3] Orygen Youth Health Clinical Program, Parkville, and [4] Travancore School, Travancore, Victoria, Australia

Corresponding author: Professor Eóin Killackey, Orygen — The National Centre of Excellence in Youth Mental Health Centre, 35 Poplar Road, Parkville, Vic. 3052, Australia. Email: eoin.killackey@orygen.org.au

Financial Disclosure: Funding for this study was provided by the State Government of Victoria, Department of Education. Killackey was in receipt of a Ronald Philip Griffiths Fellowship from the Faculty of Medicine Dentistry and Health Sciences at The University of Melbourne at the time this work was conducted. He is currently supported by the National Health and Medical Research Council through a Career Development Fellowship Level II. Allott is currently supported by a Ronald Philip Griffiths Fellowship, Faculty of Medicine Dentistry and Health Sciences, The University of Melbourne. Ring is an employee of the Department of Education in her role of Vice-Principal at Travancore School.

Received 31 July 2015; accepted 28 March 2016

Abstract

Aim: This study aimed to evaluate the feasibility and effectiveness of adapting individual placement and support (IPS) to education for young people presenting to a tertiary mental health service who wished to re-engage with or be supported in their education.

Methods: The study was an uncontrolled trial. Twenty young people with severe mental illness were recruited and worked with an educational specialist providing adapted IPS for education (IPSed). Demographic, educational and symptom measures were collected at baseline. Educational outcome was collected at the end of the 6-month intervention. Data presented are descriptive.

Results: Individual placement and support for education was found to be feasible with 95% of the participants successfully completing the intervention. Eighteen of the 19 who participated through to the conclusion of the intervention achieved positive educational outcomes.

Conclusions: It is well established that education is the foundation of career, but many people with mental illness drop out of their education with the onset of illness in adolescence or early adulthood. There has been a dearth of interventions to reconnect people with mental illness to secondary education and training. This study demonstrates that it is feasible to adapt IPS to focus exclusively on education at the outset of illness. Further larger studies are needed to confirm these results and create an evidence base for implementation of IPSed in routine practice for the treatment of early stage mental illness.

Key words: education, individual placement and support, vocational recovery, youth mental health.

OBJECTIVE

Education is the foundation of career. In both the general community[1,2] and in communities of people with mental illness,[3] increased educational attainment has been shown to be predictive of employment and of higher income, allowing for greater economic and social participation. However, an impact of the typical onset of mental illness occurring in adolescence and early adulthood[4] is the disruption or derailment of education.[5] This is particularly so in relation to secondary education.[6] Consequently, compared with the general population, a larger proportion of people who develop mental illness do not complete secondary education or its equivalent, and they have a much lower rate of post-secondary educational achievement.[6,7] Traditional supported education

approaches are defined as being concerned with post-secondary education.[8] For young people who have not finished or who wish to re-engage with secondary level education, a different approach is required.

Even though there is a lack of focus of supported education on the secondary level, and despite data showing significant disruption to secondary education,[6] young people with mental illness consistently identify education as a primary goal.[9–11] However, there are few interventions targeting educational rehabilitation with a focus on young people in the early stages of illness.[12] Those that have been evaluated, in keeping with the hitherto stated aims of supported education,[8] tend to focus on adults with schizophrenia reconnecting with *post-secondary* study. For example, in the largest supported education study (N=397),[13] participants had either finished high school or were in the process of gaining high school equivalency. The average age of the sample was 37 years, and participants had mental illness for a mean of 14 years.[14] Some authors have suggested that the appropriate role of supported education interventions is in the support of post-secondary training.[8,15] The opportunity to support the completion of secondary education at the outset of illness and hence limit the development of vocational disability while simultaneously building the foundation for career seems to have been missed.

Individual placement and support (IPS) is an approach that has a proven track record of efficacy in helping people with severe mental illness return to employment.[16] Importantly, it has also demonstrated efficacy at the outset of illness.[17,18] IPS has eight principles.[19] It has been suggested that IPS should be adapted to include supported education as an augmentation to its employment function. In the case of first-episode psychosis, this has been done by including educational goals and outcomes as targets where clients indicated that they wanted to focus on education in their vocational recovery.[17,18] This is also the approach taken in the RAISE SEE intervention that integrated employment and education in an adaptation of IPS for young people with psychosis.[20] Interestingly, while IPS produces superior results with respect to employment in young people with early-stage mental illness, the outcomes for education are no better than in control conditions.[21] However, the present study sought to further this work in two ways. Firstly, instead of adding on education to employment, we sought to focus exclusively on education. To that end, we adapted IPS to education by substituting the employment consultant for a person with expertise in education (a qualified teacher). Secondly, we adapted the seven education relevant IPS principles as follows:

1 Individual placement and support for education (IPSed) is focussed on enrolment in a community education or training course as an outcome at a level appropriate to the individual.
2 Individual placement and support for education is open to any person with mental illness who would like to return to school/training or who feels that they would like extra support to remain in their current educational environment. Acceptance into the program is not determined by measures of learning-readiness or illness variables.
3 Identifying appropriate courses and where possible enrolment into them commences directly on entry into the program.
4 Individual placement and support for education is integrated with the mental health treatment team.
5 Potential courses are chosen based on consumer preference with reference to their educational and career goals.
6 The support provided in IPSed is time-unlimited, continuing where possible to the end of the course or where the student no longer feels the support is necessary.
7 The education consultant makes relationships with local education providers.

The aim of this project was to explore if adapting IPS to education was feasible with young people presenting for the first time with a severe mental illness and if it had the potential to lead to successful educational outcomes.

METHODS

Setting

The study was carried out at Orygen Youth Health Clinical Program (OYHCP). OYHCP is a public mental health service for young people aged 15–25 years living in the north and north-west of metropolitan Melbourne, Australia. The catchment area covers a population of approximately 1 million people. OYHCP has a number of specialized clinics that treat young people with a range of severe mental illnesses including mood and anxiety, personality and psychotic disorders and those at ultra-high risk of developing a psychotic disorder.

Participants

Any client who expressed an interest in educational support or rehabilitation, whether that was to enrol in an educational course or to receive support to stay in a current course, was eligible to be referred by their case manager to the study. Referral could occur at any time during their engagement with OYHCP.

The study was approved by the Melbourne Health Mental Health Research and Ethics Committee.

The inclusion criteria were that the participant was a current client of OYHCP aged between 15 and 20 years. The restriction on age range was because of funding for this study being provided by the Victorian State Department of Education. The department only funds for the provision of services for people up to the age of 20 years. The participant had to have expressed a desire to pursue an educational objective.

Exclusion criteria were severe intellectual disability or florid psychosis that would have prevented the determination of ability to provide informed consent.

There was a short rolling admission over a three-month period. In keeping with IPS principles, the caseload was capped at 20.

Intervention

As discussed in the preceding texts, we adapted the well-defined method of supported employment called IPS to focus on education. We called this IPSed. In this study, we employed a teacher with over 25 years of experience working with this population and linking them back to mainstream and alternative education settings. Supervision for her practice of IPSed was provided by the vice principal of Travencore School, and clinical supervision was provided by the Head of the Psychosocial Recovery Unit of OYHCP. She collaborated with a young person to help them re-engage with their place of educational enrolment or identify educational courses that they felt matched their educational goals, prepared for enrolment and crucially and supported the person in the course. This support included transportation to the course, support in the classroom, assistance with homework or other issues that arose. In all cases, the educational specialist liaised with the client's case manager, and clinical care continued throughout. Further, the educational specialist liaised with support staff at the educational facility in order to develop the supports that the student had available to them.

Because of this being a feasibility study and funding restrictions, the intervention covered a period of approximately 6 months or a complete semester. During this time, the education specialist worked 50% of a full-time load.

Measures

As this was an exploratory study, the assessment battery was kept minimal. Details of the measures used are in the succeeding texts. The assessments were administered by a trained research assistant.

Baseline measures

For descriptive purposes, a range of baseline measures were administered. Demographic variables included age, gender, educational achievement and history; current employment; current financial support; and treatment information (Orygen sub-clinic attended, medication, compliance, family history of mental illness, etc.).

The symptom section of the assessment included a number of standard psychopathology assessments and self-report questionnaires. The Brief Psychiatric Rating Scale,[22] the Center for Epidemiological Studies – Depression[23] Scale and the Scale for the Assessment of Negative Symptoms[24] were used.

Functioning was assessed using the single-item Social and Occupational Functioning Assessment Scale.[25]

A record of whether the participant was enrolled in education and if so, whether they were attending, was recorded. Highest level of education was also recorded.

Outcome measure

At the end of the 6-month intervention, descriptive information was collected about the educational outcomes that had been achieved, specifically, whether the individual was attending and what level of education they had achieved.

Statistical analyses

As this was a small exploratory study, analyses consisted of descriptive statistics only using IBM SPSS Version 20.

RESULTS

Twenty people were rapidly referred and consented over 3 months. Nobody who was approached to participate initially refused. Assessments were conducted with 19 participants, as one person chose

not to continue in the study (reason not disclosed). The participants came from the early psychosis clinic of OYHCP (EPPIC $n=12$), the ultra-high risk clinic (PACE $n=1$) and the mood and anxiety clinic ($n=6$). For simplifying the descriptive statistics, the PACE and EPPIC groups were collapsed. Importantly, at baseline, none of the participants were attending education. 11 were enrolled and not attending and eight were not enrolled. Table 1 shows baseline demographic and clinical characteristics of the sample in total and by originating clinic.

At the 6-month outcome, 18 of the 19 participants were enrolled in education and attending. All except one were studying beyond their previous highest level of education. One participant was in hospital for most of the study period as a result of mental health. The participants' baseline level of highest academic achievement and the level engaged in following the intervention are shown in Table 2.

TABLE 2. Highest previous academic achievement and the level engaged in at outcome

Participant	Highest previous achievement	Outcome level
1	Year 11	Year 12 part-time
2	Year 10	TAFE full-time
3	Year 11	Year 12 full-time
4	Year 8	Year 10 part-time
5	Year 10	TAFE full-time
6	Year 9	TAFE full-time
7	Year 12	TAFE part-time
8	Year 9	Year 10 full-time
9	Year 11	Year 12 full-time
10	Year 10	Year 12 full-time
11	Year 6	Year 12 part-time
12	Year 9	Year 11 full-time
13	Year 9	Year 10 full-time
14	Year 11	Year 12 full-time
15	Year 10	Year 11 full-time
16	Year 10	Year 11 full-time
17	Year 11	Year 12 part-time
18	Year 10	Year 11 part-time
19	Year 10	In hospital

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

This study examined the feasibility of IPSed in a group of young people aged 15–19 receiving treatment at a tertiary mental health service. In indication that IPSed was feasible was the high demand for this intervention demonstrated by the caseload of the education specialist reaching capacity within 3 months, and that 95% of the sample remained in the study throughout. The demand for an educational intervention is not surprising. As well as being obviously important to vocational development,[26] education is named as a primary life and treatment goal by young people with severe mental illness.[9,10] In the present study, because

TABLE 1. Baseline demographics and clinical characteristics

	EPPIC ($n=13$)	Mood and anxiety ($n=6$)	Total ($n=19$)
Sex	Female 9 (69.2%)	Female 3 (50%)	Female 12 (63.2)
Age	17.5 (1.0)	17.4 (1.2)	17.5 (1.0)
Highest level of school passed			
6	1 (7.7%)	0 (0%)	1
7	0 (0%)	0 (0%)	0
8	1 (7.7%)	0 (0%)	1
9	4 (30.8%)	0 (0%)	4
10	3 (23.1%)	4 (66.7%)	7
11	3 (23.1%)	2 (33.3%)	5
12	1 (7.7%)	0 (0%)	1
Ever married	0	0	0
Have children	0	0	0
Born in Australia	12 (92.3%)	4 (66.7%)	16
CESD	22.5 (11.1)	28.8 (13.2)	24.5 (11.8)
BPRS	47.9 (9.4)	44.3 (16.5)	46.8 (11.7)
BPRS PS	8.9 (2.2)	6.8 (4.3)	8.3 (3.1)
SANS	15.9 (9.7)	23.5 (19.1)	18.3 (13.3)
SOFAS	61.0 (5.5)	59.7 (9.9)	60.6 (6.9)
Medication			
Antipsychotics	9 (69.2%)	1 (16.7%)	10/19
Compliance	4.0 (0.0)	4 (—)	4.00 (0.00)
Antidepressants	4 (36.4)	4 (66.7%)	8/17 (2 missing)
Compliance	3.8 (0.4)	3.5 (1.0)	3.7 (0.67)

funding came from the State Department of Education, we were not able to include people aged 20–25. It is possible that people in this older age group may be equally keen to re-engage with their education as they become more aware of the vocational disadvantage of restricted educational achievement. A further measure of the feasibility of IPSed is that as with IPS for employment, it integrated well with the clinical team. Although not formally measured, there were no reports of any adverse impact on ongoing clinical care from the study.

In terms of outcomes, this small feasibility study provides preliminary, but encouraging, results suggesting that IPSed may be an effective intervention for young people with mental illness who wish to re-engage with education that has been disrupted by the onset of their illness. At outcome, 18 out of 19 (95%) were actively engaged with their education, and all bar one of them at levels higher than the point at which they had previously disengaged. That the majority of the sample had a favourable outcome suggests that symptom status at baseline is not necessarily associated with outcome and should not be used as a justification to prevent people from pursuing their educational goals. Waghorn and colleagues have shown that people with psychosis have less education,[6] a fact that is also true for people with non-psychotic illnesses.[27] The corollary of this is that people with mental illness do not experience the same employment opportunities and rewards as the rest of the community. There is encouraging evidence that this intervention goes some way to addressing that.

Individual placement and support has been very successful for employment outcomes in adults and young people with severe mental illness. As more attention is given to the vocational functioning of young people with mental illness, greater focus is needed on their educational attainment. While it has been shown that many IPS programs are also providing supported educational interventions,[28] there is a dearth of literature examining educational interventions for young people re-engaging with secondary level schooling or training. In some ways, the question could be posed: Does the lack of focus on education as an intervention expose a hidden acceptance of the vocational stigma attached to people with mental illness by those working in the mental health field? In order to ensure that people with mental illness do not have their vocational options reduced, education must be a key part of the vocational offering to them. As early intervention in mental illness becomes an increasing feature of mental health services worldwide, focussing on functional domains such as education becomes more important. This study indicates that this is both feasible and potentially effective.

Limitations

There are a number of limitations that must be considered in relation to the present study. The first is that this was an uncontrolled trial. As such, it is possible that these results would have occurred anyway. Mitigating against this being either a chance finding or something that would have happened anyway is the well-known lack of educational success in this population. The study was very small with a sample of 20 – 19 of whom completed the trial. Further, the only outcome considered was education. As mentioned, we were restricted in the age range of participants we could include, and it may be that including the full range of young people (15–25 years) would have produced different outcomes. This study utilized a teacher with significant experience working similarly to the model of IPSed. To generalize this intervention in future research or practice, training would be required to be developed. There was no measurement of fidelity to the model in this study. This is in part because the model does not have a fidelity scale. Such a scale, specific to IPSed, is needed for future studies and clinical practice. Because of limitations imposed by the level of the funding of the study, there was no capacity for a longer term follow-up of these clients. Therefore, it is not possible to speculate about the persistence of a positive effect from the intervention.

Conclusion

Personal accounts of the lived experience of mental illness testify to the benefit of being supported to engage in education.[29] As well as the benefits of linking to career, education is a powerful intervention for allowing the individual to stay connected or reconnect with their own sense of identity beyond a sick role. As the onset of illness most typically happens in adolescence and early adulthood, there is a pressing need to have specialist interventions at the outset of treatment to reconnect people with their education. This study provides preliminary evidence of the capacity of IPS adapted for education to do just that. However, further research is needed in order to establish the evidence base for IPSed, as well as justify the economic case for its inclusion in routine service delivery.

REFERENCES

1. Australian Bureau of Statistics. *Education and Training Experience*. Canberra: Australian Bureau of Statistics, 2010.
2. Bureau of Labor Statistics. Earnings and unemployment rates by educational attainment. 2015; http://www.bls.gov/emp/ep_chart_001.htm. Accessed 30/07/2015, 2015.
3. Waghorn G, Chant D, Whiteford H. The strength of self-reported course of illness in predicting vocational recovery for persons with schizophrenia. *J Vocat Rehabil* 2003; **18** (1): 33–41.
4. Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustun TB. Age of onset of mental disorders: a review of recent literature. *Curr Opin Psychiatry* Jul 2007; **20** (4): 359–64.
5. Swanson CL Jr, Gur RC, Bilker W, Petty RG, Gur RE. Premorbid educational attainment in schizophrenia: association with symptoms, functioning, and neurobehavioral measures. *Biol Psychiatry* Oct 1998; **44** (8): 739–47.
6. Waghorn G, Saha S, Harvey C *et al.* 'Earning and learning' in those with psychotic disorders: the second Australian national survey of psychosis. *Aust N Z J Psychiatry* August 1, 2012 2012; **46** (8): 774–85.
7. Kessler RC, Foster CL, Saunders WB, Stang PE. Social consequences of psychiatric disorders, I: educational attainment. *Am J Psychiatry* Jul 1995; **152** (7): 1026–32.
8. Rogers ES, Kash-MacDonald M, Bruker D, Maru M. Systematic review of supported education literature, 1989–2009. 2010; http://www.bu.edu/drrk/research-syntheses/psychiatric-disabilities/supported-education/. Accessed 10/12/2014, 2014.
9. Ramsay CE, Broussard B, Goulding SM *et al.* Life and treatment goals of individuals hospitalized for first-episode nonaffective psychosis. *Psychiatry Res* Oct 30 2011; **189** (3): 344–8.
10. Iyer SN, Mangala R, Anitha J, Thara R, Malla AK. An examination of patient-identified goals for treatment in a first-episode programme in Chennai. *India Early Interv Psychiatry* 2011; **5** (4): 360–5.
11. Morgan VA, Waterreus A, Jablensky A *et al.* People living with psychotic illness 2010. In: *Department of Health and Ageing*. Canberra: Commonwealth of Australia, 2011.
12. Goulding SM, Chien VH, Compton MT. Prevalence and correlates of school drop-out prior to initial treatment of nonaffective psychosis: further evidence suggesting a need for supported education. *Schizophr Res* 2010; **116** (2–3): 228–33.
13. Mowbray CT, Collins ME, Bellamy CD, Megivern DA, Bybee D, Szilvagyi S. Supported education for adults with psychiatric disabilities: an innovation for social work and psychosocial rehabilitation practice. *Soc Work* Jan 2005; **50** (1): 7–20.
14. Mowbray CT, Collins M, Bybee D. Supported education for individuals with psychiatric disabilities: long-term outcomes from an experimental study. *Soc Work Res* Jun 1999; **23** (2): 89–100.
15. Murphy AA, Mullen MG, Spagnolo AB. Enhancing individual placement and support: promoting job tenure by integrating natural supports and supported education. *Am J Psychiatr Rehabil* 2005; **8** (1): 37–61.
16. Bond G. Evidence for the effectiveness of the individual placement and support model of supported employment. 2012; http://www.dartmouth.edu/~ips2/resources/12-ips-evidence-10-23.pdf. Accessed November 20, 2012.
17. Killackey E, Jackson HJ, McGorry PD. Vocational intervention in first-episode psychosis: a randomised controlled trial of individual placement and support versus treatment as usual. *Br J Psychiatry* 2008; **193**: 114–20.
18. Nuechterlein KH, Subotnik KL, Turner LR, Ventura J, Becker DR, Drake RE. Individual placement and support for individuals with recent-onset schizophrenia: integrating supported education and supported employment. *Psychiatr Rehabil J* Spring 2008; **31** (4): 340–9.
19. Drake R, Bond G, Becker D. *Individual Placement and Support: An Evidence-Based Approach to Supported Employment (Evidence-Based Practice)*. New York: Oxford University Press, 2012.
20. Mueser KT, Penn DL, Addington J *et al.* The NAVIGATE program for first-episode psychosis: rationale, overview, and description of psychosocial components. *Psychiatr Serv* Jul 1 2015; **66** (7): 680–90.
21. Bond GR, Drake RE, Luciano A. Employment and educational outcomes in early intervention programmes for early psychosis: a systematic review. *Epidemiol Psychiatric Sci* 2015. **24** (5): 446–57.
22. Overall JE, Gorham DR. The Brief Psychiatric Rating Scale. *Psychiatic Rep* 1962; **10**: 799–812.
23. Radloff LS. The CES-D Scale: a self-report depression scale for research in the general population. *Appl Psychol Meas* Sum 1977; **1** (3): 385–401.
24. Andreasen NC. *Scale for Assessment of Negative Symptoms (SANS)*. Iowa City: University of Iowa, 1984.
25. Goldman HH, Skodol AE, Lave TR. Revising axis V for DSM-IV: a review of measures of social functioning. *Am J Psychiatry* Sep 1992; **149** (9): 1148–56.
26. Mueser KT, Cook JA. Supported employment, supported education, and career development. *Psychiatr Rehabil J* Dec 2012; **35** (6): 417–20.
27. Degney J, Hopkins B, Hosie A, Lim S, Rajendren AV, Vogl G. *Counting the Cost — The Impact of Young Men's Mental Health on the Australian Economy*. Melbourne: Inspire Foundation and Ernst & Young, 2012.
28. Manthey TJ, Holter MC, Rapp CA, Davis JK, Carlson L. The perceived importance of integrated supported education and employment services. *J Rehabil* 2012; **78** (1): 16–24.
29. Rinaudo B, Ennals P. Mental illness, supported education, employment and recovery: Ben's story. *Work* 2012; **43**: 2012.

Vocational intervention in first-episode psychosis: individual placement and support v. treatment as usual

Éoin Killackey, Henry J. Jackson and Patrick D. McGorry

BJP 2008, 193:114-120.
Access the most recent version at DOI: 10.1192/bjp.bp.107.043109

BJPsych | The British Journal of Psychiatry (2008) 193, 114–120. doi: 10.1192/bjp.bp.107.043109

Vocational intervention in first-episode psychosis: individual placement and support *v.* treatment as usual

Eóin Killackey, Henry J. Jackson and Patrick D. McGorry

Background
Unemployment is a major problem for people with first-episode psychosis and schizophrenia. This has repercussions for the economy, social functioning and illness prognosis.

Aims
To examine whether a vocational intervention – individual placement and support (IPS) – which has been found to be beneficial in populations with chronic schizophrenia, was a useful intervention for those with first-episode psychosis.

Method
A total of 41 people with first-episode psychosis were randomised to receive either 6 months of IPS + treatment as usual (TAU) (n=20) or TAU alone (n=21).

Results
The IPS group had significantly better outcomes on level of employment (13 *v.* 2, $P<0.001$), hours worked per week (median 38 *v.* 22.5, P=0.006), jobs acquired (23 *v.* 3) and longevity of employment (median 5 weeks *v.* 0, P=0.021). The IPS group also significantly reduced their reliance on welfare benefits.

Conclusions
Individual placement and support has good potential to address the problem of vocational outcome in people with first-episode psychosis. This has economic, social and health implications.

Declaration of interest
This research was supported by a National Health and Medical Research Council Program Grant (ID: 350241) and an unrestricted study grant from Bristol Myers Squibb. ORYGEN Research Centre is supported by the Colonial Foundation.

A key problem facing people with psychotic illnesses is unemployment.[1] This is despite surveys consistently showing that gaining a job in open employment is a primary goal of most people with mental illnesses.[2] Unemployment is the largest contributor to indirect costs of psychotic illnesses.[3,4] In response to this problem, a method of vocational intervention called 'individual placement and support' (IPS) has been developed. This highly defined form of supported employment has proven, through a number of randomised controlled trials, to be an effective intervention for people with chronic mental illness.[5] However, there have been no published randomised controlled trials of this approach in those with first-episode psychosis, a group who also have high levels of unemployment and who are normally in a phase of life where vocational development typically occurs. This study aimed to examine the effectiveness of IPS in a group of young people with first-episode psychosis who wanted to find work.

Method

Participants

Between October 2005 and April 2006, 41 people who were attending a specialist public mental health service and who wanted help in finding work were recruited to the study. All were patients of the Early Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne, Australia. This service treats all cases of a first-episode of psychosis in people aged between 15 and 25 years living in a defined catchment area of about 1 million people. Within this catchment area, the number of people aged 15–25 years is estimated to be 250 000.

Individuals were eligible for the study if they wanted to find work (including a different job if they currently held one) and had at least 6 months of care left at EPPIC (EPPIC is limited to providing 18 months of care). The only exclusion criterion was lack of fluency in English. Nobody needed to be excluded on this basis.

Informed consent was required to participate in the study, and decisions regarding participation did not influence clinical care in any way. Participants were recruited via EPPIC case managers identifying people from their case-load who were interested in seeking work. There were no refusers. Assessments were conducted by an experienced, trained research assistant who was also an advanced psychology doctoral student. Assessments were generally conducted at EPPIC but some were also completed in participants' homes.

Interventions

In this study, IPS + treatment as usual (TAU) (the vocational-intervention group) was compared with TAU alone as there is no established evidence-based vocational intervention for those with first-episode psychosis. Treatment as usual consisted of participants continuing to receive EPPIC care. This involves individual case management and medical review, referral to external vocational agencies, as well as involvement with the group programme at EPPIC, which may involve participation in the vocationally oriented groups within the group programme. Treatment as usual was delivered primarily by EPPIC case managers.

Individual placement and support is a highly defined form of supported employment and has six key principles:

(a) it is focused on competitive employment (i.e. jobs which are not set aside but open to applications from anyone with the appropriate skills or qualifications) as an outcome;

(b) it is open to any person with mental illness who chooses to look for work and acceptance into the programme is not determined by measures of work-readiness or illness variables;

(c) job searching commences directly on entry into the programme;

(d) the IPS programme is integrated with the mental health treatment team;

(e) potential jobs are chosen based on consumer preference;

(f) the support provided in the programme is time-unlimited, continuing after employment is obtained, and is adapted to the needs of the individual.[6]

A seventh principle, also sometimes considered as part of the model of IPS, is welfare benefits counselling,[7] as there are often disincentives to be negotiated in the transition from a welfare benefit to paid employment.[1,8] These can include loss of concessions for transport and utilities, high effective marginal tax rates and loss of public health access. Strong evidence supports the first four of the seven IPS principles as being necessary to successful implementation of the model.[7] The other three principles have only weak evidence to support their inclusion.[7] In the present trial, this vocational intervention was delivered by an employment consultant employed for the project.[9] She was co-located with the clinical team and attended clinical review meetings. She delivered the intervention both on-site and off-site, and via phone calls. Location and frequency of service delivery was based on individual needs.

Objectives

The objectives of this study were to compare the effectiveness of vocational intervention with a control condition of TAU in helping people with first-episode psychosis find work or enter a course congruent with their career aims. It explored the following hypotheses:

(a) that those in the vocational-intervention group would have better outcomes (defined as employment or enrolment in a course) within 6 months than those in the TAU group;

(b) that people in the intervention group would obtain more jobs than those in the TAU group;

(c) that people in the intervention group would work more weeks and earn more money than those in the TAU group;

(d) that those in the intervention group would use welfare benefits less than those in the TAU group.

Outcomes

As this study was concerned only with the effectiveness of IPS as a vocational intervention, and as there is little evidence in the literature of vocational outcomes having an effect on symptom outcomes, the primary outcomes reported here are numbers of jobs and courses, longevity of work, money earned and level of access to welfare benefits. Secondary outcomes which are beyond the scope of this report would be the effect of employment on symptoms and quality of life domains.

Measures

In both groups assessment occurred at baseline and at 6 months, following the conclusion of the intervention in the intervention group. Assessment at both times covered a number of demographic, symptom, diagnostic and functioning areas as detailed below.

Baseline descriptive measures

Demographic data included age, gender, employment and educational history, length of illness, medication dosage and adherence, living situation, marital status, current employment status and welfare benefit status.

The Brief Psychiatric Rating Scale[10] was used to measure the presence and severity of psychopathology during the previous 2 weeks. Negative symptoms were assessed by the Scale for the Assessment of Negative Symptoms.[11] Depression was measured by the Center for Epidemiologic Studies Depression Scale–Revised.[12]

Diagnoses were reached by means of the Structured Clinical Interview for DSM–IV–TR Axis 1 Disorders – Patient Edition (SCID–I/P).[13]

Two measures were used to assess functioning. The first was the Quality of Life Scale[14] – a 21-item semi-structured interview which provides a total score comprised of four sub-scales: intrapsychic foundations, interpersonal relations, instrumental role, and common objects and activities. Only the total score is reported in this paper. The second measure used to assess functioning was the Social and Occupational Functioning Assessment Scale (SOFAS).[15] The SOFAS is a 100-point single-item scale in which the assessor rates the individual according to their lowest level of functioning in the past month. Scores range from 0 to 100 with 100 indicating superior functioning in a wide range of activities, and lower scores indicating lower levels of functioning. The SOFAS score is indicative of social and occupational functioning and does not take into account level of psychopathology.

Primary outcome measures

The primary outcome measures in this project were: the number of jobs a participant had held in the intervention period; the hourly rate of pay and the number of hours worked per week; the number of weeks in each job or in their current job at the time of follow-up; the number of courses that a participant had completed or was currently enrolled on at the time of follow-up; and welfare benefit receipt status.

Fidelity measures

The Supported Employment Fidelity Scale–Implementation Questions[16] was used to assess the fidelity of the programme to the IPS model. This was assessed by E.K. (and reviewed with an interstate colleague independent of the project from the only other research group working in this area in Australia) by using existing knowledge of the programme parameters and by direct observation of the clinical team and the employment consultant.

Sample size

Sample size was determined by pragmatic considerations as there were no previous randomised studies of vocational interventions in this population to guide us. In the end, 41 people were recruited. There were 20 people in the intervention group and 21 in the TAU group. One person dropped out from the intervention group and 5 from the TAU group (Fig. 1). Four people from the TAU group dropped out because they had enrolled wanting help to find work and felt that as they were not getting it they no longer wished to continue in the project. The remaining two people (one in each group) dropped out as they were sent to jail for offences that occurred before their enrolment in the trial. However, all who dropped out gave their permission for their employment status at follow-up to be determined from their case manager and medical records.

Randomisation

Participants were randomised by a statistician independent of the study using computer-generated random numbers to carry out

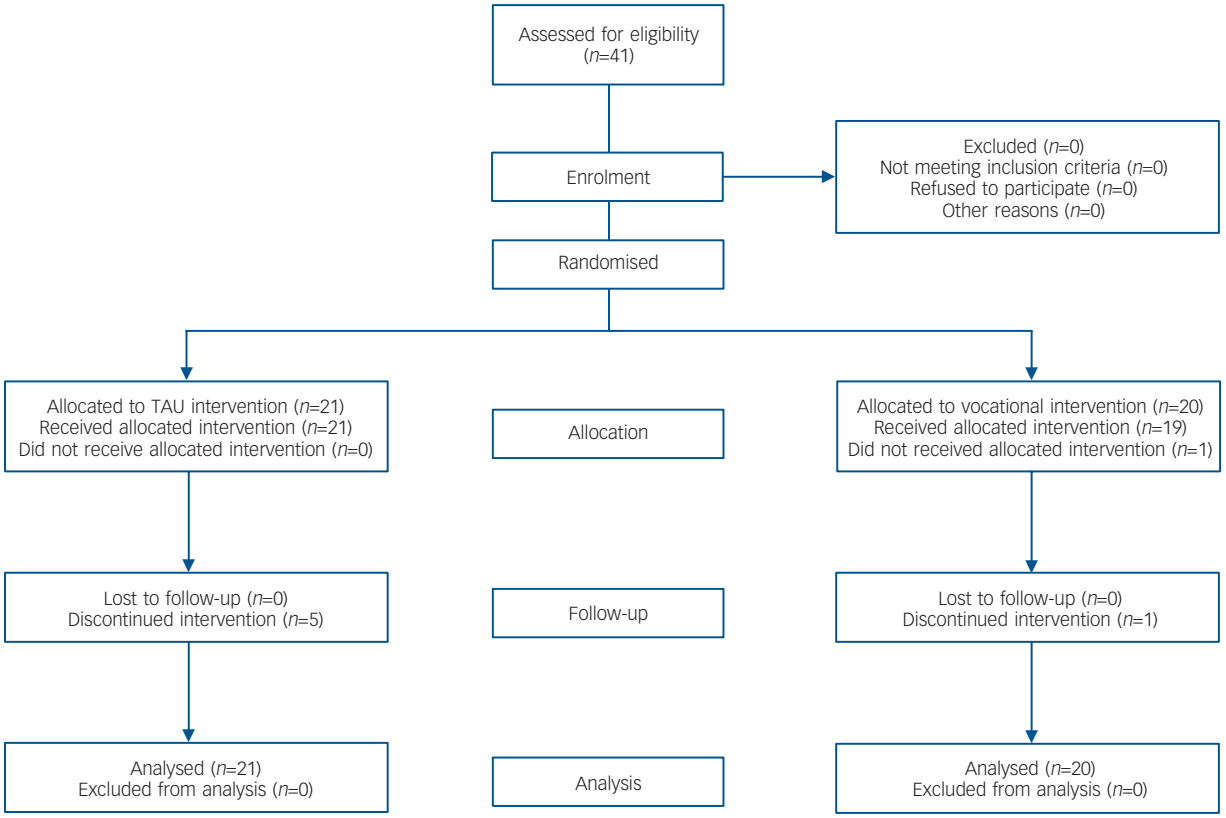

Fig. 1 Flow diagram of study participants. TAU, treatment as usual.

blocked randomisation to one of the two conditions. The statistician would be contacted by the leader of the project (E.K.) when a new participant enrolled and the statistician would inform E.K. of the group allocation. This information would then be given to the participant, the case manager of the participant and also the employment consultant if allocation was to the intervention group. The research assistant was not involved in this process, but there were no formal tests of her masking to allocation.

Statistical methods

Statistical analysis was conducted using SPSS version 14.0 for Windows. Group differences were calculated using independent-samples *t*-tests and chi-squared analysis. Logistic regressions were conducted to ensure that differences observed in main outcome variables were related to group membership rather than variables that were different at baseline.

Results

Baseline data

There were no significant differences between the groups on most of the demographic or symptom variables at baseline (Table 1). There was a difference in marital status. As more people in the TAU group were in marital or marital-like relationships, this would tend to bias the study against finding success for the vocational intervention, as people in marital relationships tend to function better socially and in employment.[17] There was a significant difference between the groups on the SOFAS, with the TAU group having a higher SOFAS score than the intervention group. This again would bias the study against the success of the intervention group. Importantly, there were no differences between groups in either medication levels or self-reported medication adherence. All participants were patients of a specialised public first-episode psychosis service and had received clinical diagnoses of schizophrenia-spectrum disorders. On assessment with the SCID–I/P, in addition to their primary psychotic disorders, all but 5 had other comorbid disorders: 20 had a mood diagnosis, 1 had a pervasive developmental disorder, 3 had anxiety diagnoses, 23 had substance use diagnoses and 7 had other diagnoses.

At baseline, 1 person in the intervention group was working in a part-time job and 2 people in the TAU group were working, 1 full-time and 1 part-time.

Dosing of the intervention

On average, the employment consultant had 29.55 (s.d.=11.45) contacts with each participant in the intervention group across the 6-month intervention. Of these, most (19.3) were by telephone and the others were split evenly between in-office (5.05) and out-of-office (5.2) contacts. Total number of contacts was significantly correlated with number of job interviews (r=0.511, P=0.025); number of job interviews was correlated with employment outcome (r=0.347, P=0.044). On average, those in the intervention group had 3.00 (s.d.=4.72) job interviews, compared with 1.47 (s.d.=2.77) for those in the TAU group. Ten of the participants in the TAU group used an external employment agency. None of these obtained work during the period of the trial. There was no evidence of a cumulative time effect of the intervention for those in the intervention group. Of the 13 who found employment, 3 worked for more than 20 of a possible 26 weeks, 5 worked

Table 1 Demographic and illness variables of participants at baseline[a]

Variable	Treatment-as-usual group	Vocational-intervention group	Significance
Age, years	21.42 (2.21)	21.29 (2.39)	NS
Gender, male/female	17/4	16/4	NS
Age at onset, years	20.47 (2.61)	19.95 (2.93)	NS
Length of illness, months	12.25 (12.98)	15.68 (14.17)	NS
Time at EPPIC, months	8.89 (12.88)	9.55 (8.30)	NS
Marital status, *n*			
Married/defacto	7	1	*P*=0.002
Never married	10	19	
Education (highest level achieved), *n*			
Year 7	1	1	NS
Year 8	0	4	
Year 9	4	3	
Year 10	4	6	
Year 11	1	1	
Year 12	7	4	
English, *n*			
Poor	0	0	NS
Fair	0	0	
Good	1	2	
Native language	16	17	
SOFAS	57.35 (10.39)	49.79 (10.53)	*P*=0.037
Medication, mg[b]	281.25 (113.98)	347.66 (135.42)	NS
BPRS	34.12 (8.10)	37.00 (8.7)	NS
CESD–R	18.81 (11.64)	20.94 (15.05)	NS
SANS	18.47 (14.27)	26.58 (16.84)	NS
QOL	78.35 (18.74)	72.21 (13.95)	NS

BPRS, Brief Psychiatric Rating Scale; CESD–R, Center for Epidemiologic Studies Depression scale–Revised; EPPIC, Early Psychosis Prevention and Intervention Centre; NS, not significant; QOL, Quality of Life scale; SANS, Scale for the Assessment of Negative Symptoms; SOFAS, Social and Occupational Functioning Assessment Scale.
a. Values shown as mean (s.d.) unless otherwise indicated.
b. Chlorpromazine equivalent.

for between 10 and 20 weeks, and 5 worked between 1 and 10 weeks.

Fidelity of the intervention

Scoring the intervention in consultation with an independent researcher using the Supported Employment Fidelity Scale–Implementation Questions[16] indicated that the intervention was carried out with high fidelity (68/75).

Overall outcome

The primary outcome of this study was whether or not young people with first-episode psychosis who wished to find work were helped in their vocational pursuits through access to an IPS programme with high fidelity to the IPS model. Overall, 13 of 20 people in the intervention group found employment compared with 2 of 21 in the TAU group. In each group, 4 people enrolled in courses but did not find employment. Of those who found work, 3 in the intervention group and 1 in the TAU group also enrolled in courses. Results of individual hypotheses will now be reported.

Hypotheses testing

Hypothesis one

In the vocational-intervention group, 17 out of 20 people either had found a job, enrolled in a course or did both, compared with 6 out 21 in the TAU group ($\chi^2(1)=13.24$, $P<0.001$) (Fig. 2). When only employment was considered as an outcome, the difference was still significant ($\chi^2(1)=13.59$, $P<0.001$ (TAU 2/21 *v.* intervention 13/20)) (Fig. 3).

A range of jobs were undertaken by those who found work in this project. In the vocational-intervention group this included: meat/chicken factory process worker, sandblasting labourer, apprentice panel beater, factory hand (data dotting), nursery hand (sprout picking), vehicle dismantling trade assistant, meat packing, warehouse order picker, service personnel, bricklayer, factory hand, recruitment agency resourcer, tyre fitter, landscaping labourer, chemical processor, bar attendant, call-centre operator, website developer, product stocker and apprentice hairdresser.

Courses undertaken were in keeping with vocational objectives. Participants were supported by the employment consultant as though they were in a job (and courses were often for a licence or certificate for employment required in the participant's desired area of work). Courses included forklift licence training; occupational health and safety; responsible service of alcohol; first-aid; secondary school classes; degree in screen printing; and diploma in cleaning.

In the TAU group, only two participants gained employment during the study. One worked for only 1 week (in a labouring job) and the other worked for the entire period of the study (in two jobs which were concurrent for 5 weeks at one stage, thus giving him 31 weeks of employment in a 26-week period; Table 2). In addition, this person also held a third job on entry into the study.

Hypothesis two

Those in the intervention group were able to find more jobs than those in the TAU group: 23 jobs *v.* 3 jobs respectively, were

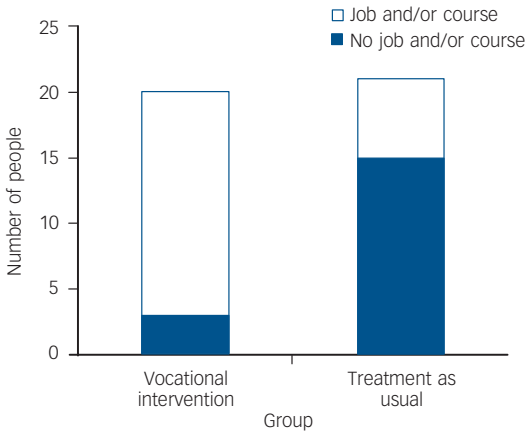

Fig. 2 Employment and enrolment status by group.

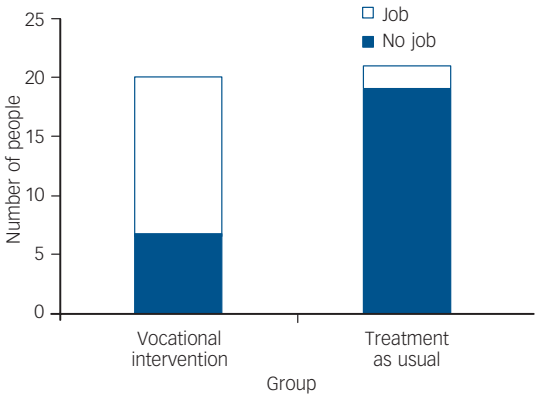

Fig. 3 Employment status by group.

obtained over the intervention period (Mann–Whitney *U*-test: $Z=-2.964$, $P=0.006$).

Hypothesis three

As can be seen in Table 2, people in the intervention group worked more weeks and earned more money overall than those in the TAU group. They also had more hours per week in those jobs. Because of the low number in the TAU group who earned any income, the effect is not seen in the dollars per hour result.

Hypothesis four

At baseline, 80% of the intervention group listed welfare benefits as their primary source of income, compared with 57.1% of people in the TAU group. At the end of the intervention, there had been a reduction of 25% to 55% of people with benefits as their primary income in the intervention group, compared with a 0% decrease in the TAU group. Two separate Cochran's *Q*-tests were conducted to determine whether there was significant change in use of benefits within the TAU and intervention groups. The change in use of benefits was not significant for the TAU group (c2(1)=1.0, $P=0.317$); however, there was significant change in the intervention group (c2(1)=5.0, $P=0.025$).

Regression analyses

In order to ensure that the variables which were different between the groups at baseline (SOFAS score and marital status) were not responsible for the difference in outcomes between groups, regression analyses were carried out. In the first regression, enrolment in a course or a job was the dependent variable, and SOFAS and marital status were independent variables. In the second, employment alone was the dependent variable and the same independent variables were used. Marital status and SOFAS score were entered before group (intervention or TAU). In the first step of the first regression, neither marital status ($P=0.051$) nor SOFAS score ($P=0.536$) was significant. When group was added, SOFAS became significant ($P=0.023$, OR=1.179), group was significant ($P=0.005$, OR=260.658) and marital status was not significant ($P=0.421$). The model with only marital status and SOFAS score had an $r^2=0.10$. With group included, the proportion of variance explained increased from 10.49% to 43.51%.

The results followed a similar pattern for employment only as an outcome. In the first step, neither SOFAS score ($P=0.267$) nor marital status ($P=0.156$) was significant. In the second step, group ($P=0.007$, OR=4202.088) and SOFAS score ($P=0.006$, OR=1.270) were significant. The model with only marital status and SOFAS score had $r^2=0.08$. With group included, the proportion of variance explained increased from 8% to 56.21%.

Table 2 Differences between treatment-as-usual and vocational-intervention groups on median duration of employment, weekly hours, total and hourly pay

	Mean (s.d.)	Median	Maximum	Minimum
Weeks worked, *n*				
Treatment as usual	3.80 (10.07)	0.0	31	0
Vocational intervention	8.63 (9.22)	5.0	26	0
Mann–Whitney *U*-test: $Z=-2.52$, $P=0.021$				
Hours worked per week, *n*[a]				
Treatment as usual	22.50 (10.61)	22.50	30.00	15.00
Vocational intervention	33.90 (15.51)	38.00	60.00	6.00
Mann–Whitney *U*-test: $Z=-2.957$, $P=0.006$				
Pay, AU$				
Treatment as usual	3615 (12 473)	0	48 370	0
Vocational intervention	4449 (5067)	2432	14 166	0
Mann–Whitney *U*-test: $Z=-2.279$, $P=0.012$				
Pay per hour, AU$[a]				
Treatment as usual	18.00 (4.24)	18.00	21.00	15.00
Vocational intervention	16.60 (5.86)	15.00	30.00	8.30
Mann–Whitney *U*-test: $Z=-2.705$, $P=0.013$				

AU$, Australian dollar.
a. Only included those participants who worked (vocational intervention, *n*=13; treatment as usual, *n*=2).

A *post hoc* correlation analysis showed that within groups there were significant one-tailed bivariate correlations between SOFAS score and employment-only outcome in both the intervention (P=0.004, r=0.58) and TAU (P=0.022, r=0.49) groups. There was a correlation between SOFAS score and employment or enrolment outcome only in the TAU group (P=0.024, r=0.49). It makes sense that there would be no correlation in the intervention group on this measure, as 85% had a successful outcome.

Discussion

Need for vocational interventions in psychotic illness

Unemployment and lost productivity is the largest contributor to the indirect costs of psychotic illnesses.[18] Australian data show that of a total economic cost of schizophrenia to the community of AU$1.8 billion in 2001, AU$800 million were associated with unemployment.[19] In the USA, the costs associated with unemployment of people with schizophrenia in 2002 have been estimated at US$32.4 billion or 52% of all schizophrenia-related costs.[3] Similar figures have been found in European data.[20,21] An intervention which can harness the desire of people with psychotic illness to work would be of enormous benefit at the level of both the individual and the community in terms of saving money.

Potential advantages of vocational intervention in first-episode psychosis

To date nearly all of the research on vocational intervention for psychotic illness has been conducted in people with long-standing illness. However, although unemployment is a major problem for those with long-standing psychotic illnesses, people with first-episode psychosis also have high levels of unemployment. A report on the state of Australian youth showed that among 15- to 24-year-olds unemployment was approximately 5%.[22] Unemployment in studies of first-episode psychosis populations is 10 times higher (about 40–50%) than for their same-age peers in the general community.[1] The phase in life when psychosis tends to have its onset is also the period in which vocational development (the completion of education and starting work) occurs. Thus, it may be argued that vocational skills not developed at this late-adolescence/early-adulthood phase of life presage greater levels of unemployment, especially if a person's psychotic illness develops to a more chronic stage.[23] Further, there is evidence that unemployment is a risk factor for the development or exacerbation of mental illness[24] and the misuse of substances.[25] Finally, it is known that peak levels of disability develop during the early phases of psychotic illness[26] and efforts made in these phases can ameliorate if not prevent disability.[27] The most effective early-intervention programmes are known to reduce the duration of untreated illness from well over a year to only a few months.[28] Vocational intervention at this time has tremendous potential not only to provide short-term employment experience and skills, but also to prevent development of long-term unemployment and its associated personal, economic and health costs. Therefore, it would seem opportune to implement vocational interventions in the early phases of mental illness. Another advantage of intervention at this stage is that often those with illness are not yet accessing welfare benefits, which have been shown to pose a substantial barrier to participation in the workforce.[29] Even where they are, the results from our study showed that the median earned (AU$2432) over 5 weeks was more than would have been received on any Australian government welfare benefit payment over the same period (AU$476–1138 depending on age and benefit type).

Current study

This study found that compared with TAU, even where that included referral to external employment agencies, there was a significant advantage to a vocational intervention for young people with first-episode psychosis co-located with their clinical service. This advantage was evident in that those in the intervention group obtained more jobs, worked more hours, earned more money and lasted longer in their jobs than those in the TAU group. Further, the jobs that these participants were successful in acquiring covered a wide range of occupations that were congruent with their own interests and needs.

It is notable that the intervention was enthusiastically received by participants, as evidenced by the 0% refusal rate. This carried through to a low drop-out rate for those in the intervention group. The higher drop-out rate in the TAU group is not surprising in that people were participating wanting help to find work and were not receiving it. It is a testament to the generosity of the participants in the TAU group that so many stayed in the trial. In future studies, a control condition which offers this group some assistance may be of benefit.

Another factor that possibly contributed to the success of the vocational intervention was the intensity of the intervention. The employment consultant in this trial, in keeping with the IPS model, was limited to a case-load of 20 individuals. This allowed her to provide intensive assistance to participants in their search for work. In comparison, those in the employment sector regularly have case-loads of over 100 and this necessarily limits the intensity of the service they can provide, particularly to those who may need more assistance and support.

Implications of this study

Employment rehabilitation is not traditionally seen to be part of mental health services. There are many reasons which suggest that it should be. The effects of unemployment on individuals with psychotic illness, which include social marginalisation, higher risk of exacerbation and relapse, lack of role and inability to participate in the economy, have been well-documented. Likewise, unemployment has been demonstrated to compete with direct treatment costs as the largest cost associated with schizophrenia. The results of this study suggest that vocational interventions co-located with and delivered as part of a complete approach to symptomatic and functional recovery are not only desired by people with mental illness, but produce effective vocational outcomes.

Instead of being part of the mental health system, vocational services are often external agencies to which patients are referred by case managers. A second implication of these results is the failure of the current employment system to adequately assist those with mental illness to gain access to paid employment. In Australia, agencies in the employment system often engage in a long, motivation-sapping assessment phase before job searching commences. In addition, if employment is obtained, the outcome payment system for these agencies is predicated on maintaining a person in a job for 3 and 6 months. This is not always applicable to young people who may have little or no work history, and who may wish to explore different work options. The IPS approach has the flexibility to support 'vocational exploration'. Employment systems vary in different countries and economies, but there is no government-level system that we are aware of that is effectively addressing the issue of employment of people with mental illness. As a disability group, people with mental illnesses are consistently overrepresented among the unemployed and welfare recipients.[1,8]

Despite the will of people with mental illness to work, and despite the presence of agencies intended to help them find work,

in high-income societies there are still high unemployment rates among those with psychotic illness. These facts, combined with the results of this study, suggest that a co-located, early-intervention approach to vocational rehabilitation may be a better bet for governments and individuals than brokered employment services.

Limitations

This study had a small sample size and only allows preliminary conclusions to be drawn about the employment outcomes. The sample size does not provide sufficient power to examine other potentially important questions such as the impact employment has on symptoms and health system usage or the economic benefits of this intervention. Further, as there is no follow-up at this stage it is not possible to determine whether a short 6-month intervention is sufficient to lead to lasting gains in employment and employment skills. Although the jobs that participants acquired in the course of the project represent a reasonable cross-section, the courses that most participants completed were short and targeted towards specific jobs (e.g. the responsible service of alcohol course was a requirement for working in licensed premises) rather than teaching broader skills (e.g. the secondary English course). Many studies in first-episode psychosis have a majority of males, but our population in both groups was 80% male. We are unsure of the reasons for this. There may be cultural reasons prompting young males to seek work more than young females. It may also be that case managers prioritise work for males to a greater extent than they do for females. A further limitation of this study is that it lacked an economic analysis of the cost–benefit of the intervention.

This study shows that employment outcomes can be achieved; future work will need to analyse the economic benefit of this intervention in this population over normal employment methodologies.

Eóin Killackey, DPsych, Department of Psychology, School of Behavioural Science, The University of Melbourne, and ORYGEN Research Centre, Parkville; **Henry J. Jackson**, PhD, Department of Psychology, School of Behavioural Science, The University of Melbourne; **Patrick D. McGorry**, MD, ORYGEN Research Centre, Parkville, and Department of Psychiatry, The University of Melbourne, Australia

Correspondence: Dr Eóin Killackey, ORYGEN Research Centre, 35 Poplar Road, Parkville, Victoria 3052, Australia. E-mail: eoin@unimelb.edu.au

First received 18 Jul 2007, final revision 17 Feb 2008, accepted 13 Mar 2008

References

1 Killackey EJ, Jackson HJ, Gleeson J, Hickie IB, MCGorry PD. Exciting career opportunity beckons! Early intervention and vocational rehabilitation in first episode psychosis: employing cautious optimism. *Aust N Z J Psychiatry* 2006; **40**: 951–62.

2 Secker J, Grove B, Seebohm P. Challenging barriers to employment, training and education for mental health service users: the service user's perspective. *J Ment Health* 2001; **10**: 395–404.

3 Wu EQ, Birnbaum HG, Shi L, Ball DE, Kessler RC, Moulis M, Aggarwal J. The economic burden of schizophrenia in the United States in 2002. *J Clin Psychiatry* 2005; **66**: 1122–9.

4 Carr V, Lewin TJ, Neil AL. What is the value of treating schizophrenia? *Aust N Z J Psychiatry* 2006; **40**: 963–71.

5 Crowther RE, Marshall M, Bond GR, Huxley P. Vocational rehabilitation for people with severe mental illness. *Cochrane Database Syst Rev* 2001; (2): CD003080.

6 Becker DR, Drake RE. *A Working Life For People With Severe Mental Illness*. Oxford University Press, 2003.

7 Bond GR. Supported employment: evidence for an evidence-based practice. *Psychiatr Rehabil J* 2004; **27**: 345–59.

8 Turton N. Welfare benefits and work disincentives. *J Ment Health* 2001; **10**: 285–300.

9 Killackey E, Waghorn G. The challenge of integrating employment services with public mental health services in Australia: progress at the first demonstration site. *Psychiatr Rehabil J* in press.

10 Ventura J, Lukoff D, Nuechterlein KH, Liberman RP, Green MF, Shaner A. *Brief Psychiatric Rating Scale (BPRS) Expanded Version (4.0). Scales, Anchor Points, and Administration Manual*. UCLA Department of Psychiatry and Behavioral Sciences, 1993.

11 Andreasen NC. *Scale for Assessment of Negative Symptoms (SANS)*. University of Iowa, 1984.

12 Eaton WW. Centre for Epidemiologic Studies Depression Scale – Revised (CESD–R). In *Innovations in Clinical Practice: A Source Book* (eds L VandeCreek, T Jackson): 295–7. Professional Resource Exchange, 2001.

13 First MB, Spitzer RL, Gibbon M, Williams JBW. *Structured Clinical Interview for DSM–IV–TR Axis I Disorders, Research Version, Patient Edition (SCID–I/P)*. Biometrics Research, New York State Psychiatric Institute, 2001.

14 Heinrichs DW, Hanlon TE, Carpenter WT. The Quality of Life Scale: an instrument for rating the schizophrenic deficit syndrome. *Schizophr Bull* 1984; **10**: 388–98.

15 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (4th edn) (DSM–IV)*. American Psychiatric Association, 1994.

16 Becker DR, Smith J, Tanzman B, Drake RE, Tremblay T. Fidelity of supported employment programs and employment outcomes. *Psychiatr Serv* 2001; **52**: 834–6.

17 Jenkins R, Lewis G, Bebbington P, Brugha T, Farrell M, Gill B, Meltzer H. The national psychiatric morbidity surveys of Great Britain – initial findings from the Household Survey. *Int Rev Psychiatry* 2003; **15**: 29–42.

18 Knapp M, Mangalore R, Simon J. The global costs of schizophrenia. *Schizophr Bull* 2004; **30**: 279–93.

19 SANE Australia. *Schizophrenia: Costs. An Analysis of the Burden of Schizophrenia and Related Suicide in Australia*. SANE Australia, 2002.

20 Andlin-Sobocki P, Rössler W. Cost of psychotic disorders in Europe. *Eur J Neurol* 2005; **12**: 74–7.

21 Löthgren M. Economic evidence in psychotic disorders: a review. *Eur J Health Econ* 2004; **5** (suppl 1): s67–74.

22 Long M. *How Young People are Faring: Key Indicators 2005*. Dusseldorp Skills Forum, 2005.

23 McGorry PD, Hickie IB, Yung AR, Pantelis C, Jackson HJ. Clinical staging of psychiatric disorders: a heuristic framework for choosing earlier, safer and more effective interventions. *Aust N Z J Psychiatry* 2006; **40**: 616–22.

24 Dooley D. Unemployment, underemployment and mental health: conceptualizing employment status as a continuum. *Am J Community Psychol* 2003; **32**: 9–20.

25 Mitchell DP, Betts A, Epling M. Youth employment, mental health and substance misuse: a challenge to mental health services. *J Psychiatr Ment Health Nurs* 2002; **9**: 191–8.

26 Birchwood M, Fiorillo A. The critical period for early intervention. *Psychiatr Rehabil Skills* 2000; **4**: 182–98.

27 McGorry P. 'Every me and every you': responding to the hidden challenge of mental illness in Australia. *Australas Psychiatry* 2005; **13**: 3–15.

28 Killackey E, Yung AR. Effectiveness of early intervention in psychosis. *Curr Opin Psychiatry* 2007; **20**: 121–5.

29 Rosenheck R, Leslie D, Keefe R, McEvoy J, Swartz M, Perkins D, Stroup S, Hsiao JK, Lieberman J; CATIE Study Investigators Group. Barriers to employment for people with schizophrenia. *Am J Psychiatry* 2006; **163**: 411–7.

Orygen YOUTH Health
Research Centre

Tell them they're dreaming

Work, Education and Young People with Mental Illness in Australia

Tell them they're dreaming

Work, Education and Young People with Mental Illness in Australia

Orygen YOUTH Health
Research Centre

Locked Bag 10 Parkville VIC 3052 Australia
www.oyh.org.au

Tell them they're dreaming

Work, Education and Young People with Mental Illness in Australia

Acknowledgments

Thank you to the people interviewed in the research for this report:

Bevan Burkin – Disability Employment Australia

Bruce Wilson – The Education Business

Gina Chinnery – Orygen Youth Health Clinical Program

Mark Considine – Melbourne University

John Conway –Disability Employment Services Provider

Lee Crothers – Orygen Youth Health Research Centre

Jenni Devereaux – Australian Education Union

Simon William Dodd – Orygen Youth Health Research Centre

Helen Lockett – Wise Group

Joanne Moore – Travencore School

Katherine Monson – Orygen Youth Health Clinical Program

Vanessa Parletta – ORS Group

Judy Ring – Travencore school

Carsten Schley – Orygen Youth Health Research Centre

Sandra Seif – ORS Group

Tracey Swadling – Mental Illness Fellowship

Geoff Waghorn – Queensland Centre for Mental Health Research

Abbreviations

ABS – Australian Bureau of Statistics

COAG – Council of Australian Government

DES – Disability Employment Service

DES – DMS – Disability Employment Service Disability Management Service

DES –ESS – Disability Employment Service Employment Support Service

DEEWR – Department of Education Employment and Workplace Relations

DSP –Disability Support Pension

ESA – Employment Services Area

ESAt – Employment Services Assessment

FMHSS - Family Mental Health Support Services

IPS – Individual Placement and Support

JCA – Jobs Capacity Assessment

JSA – Job Services Australia

JSCI – Job Seeker Capacity Instrument

MHR:CS - Mental Health Respite: Carer Support

NDIS – National Disability Insurance Scheme

NESA – National Employment Services Association

OECD – Organisation for Economic Co-operation and Development

PhaMs - Personal Helpers and Mentors

PSP - Personal and Social Performance

SACES – South Australian Centre for Economic Studies

SEE – Skills for Education and Employment

SSSO- Student Support Services Officers

VCAL – Victorian Certificate of Applied Learning

Executive Summary

Young people with mental illness want to work. They hold this as their number one goal, in common with older adults with mental illness and adults in the general population without mental illness. They long for the benefits of employment that include but are not limited to wages. They hold a great desire to live independently and to participate in their communities. Despite their dreams of a working, contributing life, the bleak reality for a young person developing a mental illness is that their life is more likely to be characterised by unemployment than employment, by the receipt of benefits rather than the earning of a wage. This state of affairs brings with it a number of significant costs. These include the lost potential of the individual, their lost contribution to society and enormous economic costs. This report examines why this is so and makes recommendations that aim to remedy this situation.

Why does mental Illness lead to poor educational and employment outcomes for young people?

Mental illness is the illness of young people. Most onset of mental illness occurs in adolescence and early adulthood. About 75% of mental disorders will have developed by the age of 25 (McGorry et al 2011).

Because of the age of onset there are often negative impacts on educational attainment and the transition to the workforce. For example more than 65% of people with a psychotic illness have not completed Year 12 (Waghorn et al 2012). In the general population, as well as the population of people with mental illness, it is a well-established fact that more education protects against unemployment and is associated with higher incomes.

As well as education and training being interrupted or prematurely exited, there are numerous other barriers to employment such as stigma, workplace discrimination and welfare traps.

As a consequence people with mental illness are severely disadvantaged in the workforce. Employment statistics illustrate they have consistently low labour market participation rates and stubbornly high unemployment rates.

What is currently done to address this?

Presently, educational interventions are piecemeal and dependent on local champions. They suffer from a lack of resources and consequently don't deliver for young people with mental illness.

The employment services system is supposed to help people with disabilities including people with mental illness find sustainable jobs. However, employment outcomes for people with mental illness are woeful. One metric of the failure of these services is that the employment level of people with psychotic illnesses has not changed over a ten-year period, stuck at 22% (Waghorn 2012 et al). Employment outcomes for people with mental illness more generally, are also poor. For example in 2009, only 29.2% of people suffering from a psychological disability were participating in the workforce and 18.9% of those were unemployed (ABS 2009). This does not compare well to other disability groups (Ibid.).

Employment outcomes in the Disability Employment Service from March to December 2010 for people with mental illness were equally unsatisfactory: of the 4,001 people with a psychiatric disability enrolled in the DMS program only 26.6% (1,066) were placed in a job and only 14.2% (568) reached the 13 week outcome (DEEWR 2012).

As a consequence of these poor outcomes it is not surprising that there is growth rather than reduction in the proportion of people with mental illness in receipt of the Disability Support Pension. They simply have no bridge to reconnect them with the workforce that they want to be a part of, and no viable alternative pathway to pursue in order to avoid needing the DSP in the first place.

In short, the current vocational support systems fail young people with mental illness, condemning them to a marginalised and stigmatised life with reduced opportunity for social and economic participation.

What contributes to this situation?

Access: Currently an individual needs to be receiving a welfare benefit to access employment support services. Many young people in the early phases of mental illness are not yet accessing benefits as their family is supporting them. This requirement excludes them from accessing employment services at the earliest opportunity. Access is further hampered by the assessment and classification process. It has been estimated that in at least one-third of cases this process is misclassifying individuals with severe mental illness and consequently directing them to less intensive employment supports than they require (Waghorn et al 2012).

Service factors: The payment structure, particularly for disability employment services, is biased towards the provision of services rather than the attainment of outcomes. This creates a situation where agencies can still be rewarded financially without necessarily achieving employment outcomes for their clients. Similarly the fostering of competition among service providers has led to a reduction in co-operation and sharing of knowledge about ways to succeed for clients. Additionally, there are high administrative loads that restrict the time that front-line staff are able to spend assisting job seekers, as well as high caseloads that dilute the intensity of services received. Finally, the current employment services also use an approach that focuses on job readiness despite literature suggesting on-the-job experiences at work are more effective.

What does the evidence suggest?

There has been significant research into the model of employment assistance called Individual Placement and Support (IPS) (Drake et al 2012). This evidence-based employment intervention for people with mental illness has shown remarkable success both in Australian and international trials. The model averages employment outcomes almost three times the current services (Bond et al 2012). Australian and international studies have shown that for young people with severe mental illness, the success rates can be as high as 85% (Killackey et al., 2008; Neuchterlein et al., 2008). IPS adapted for young people additionally includes a focus on educational as well as employment outcomes (Chinnery and Killackey, 2014). A key element of IPS is that the service is provided as a fully integrated element of mental health treatment. Providing evidence-based vocational assistance early in the course of mental illness is crucially important for two reasons. Firstly it is known that the experience of any mental illness before age 25 is associated with more unemployment, more underemployment, lower wages and greater welfare support (Gibb et al., 2010). Secondly making an early functional recovery in severe mental illness – that is getting back to school or work – is more predictive of long-term outcomes than making an early symptomatic recovery (Alvarez-Jimenez, et al., 2012). The evidence therefore suggests that IPS should be available to young people with mental illness early in the course of their illness, and in a way that is fully integrated with their mental health treatment. In practice this would mean that IPS was provided in and by the mental health service rather than by third party agencies contracted to provide employment assistance.

Implications of the Budget on the recommendations of this report

In the 2014 Federal Budget, introduced on May 13, it was announced that people on a DSP, who are aged under 35, and who commenced on the DSP before 2011 would need to have their capacity to work reassessed. It is

> "So I said to her I'd really like to go back to school and get a job, and she said 'with your condition? You're dreaming love. The best thing you can do is just rest'"
>
> Client recounting a conversation with a relative

possible that many of the people who will be reassessed as being able to work will have a mental illness as their disability. This report already recommends that young people, who we have classified as below 25, who have a mental illness and are in receipt of a benefit should have their capacity to work reassessed at regular intervals in the context of assisting them to realise their dreams and achieve full social inclusion. However, this is only half of the solution. These people must then be linked with an effective means of locating employment, education or training. As discussed in this report, we do not believe that the results to date of the Disability Employment Services give any confidence that these agencies will be able to deliver significantly for young people with a mental illness. The policy announced in the budget makes more important our suggestion that Individual Placement and Support employment services be established and delivered through headspace (for those under 25) and through community mental health settings for those over 25. IPS is the bridge that links the vocational aspirations of people with mental illness, to the employment market. The risk of not building this essential bridge between policy and outcome is that negative consequences ensue. These are likely to be increased feelings of helplessness, rising disability and the very real possibility of increased premature death from suicidal behaviour. Ensuring easy access to high-fidelity IPS through headspace for those under 25 and community mental health settings and primary care for those over 25 will contribute greatly to the successful realisation of the government's policy goals. More importantly it will allow people with mental illness to achieve their educational and employment goals.

Summary

For young people the onset of mental illness consigns their hitherto realistic hopes of the future to unattainable dreams. The systems that should prevent this from happening, that should support, guide and shepherd these young people through this transitional phase of their lives are broken. There are no coherent or systematic policies to support the completion of education. The employment system derives significant income from this group in return for precious little. Change is urgently needed and this change must be aligned with the onset of these vocational problems, in the early stages of mental illness. This report examines the employment and welfare system in relation to young people with mental illness and education and employment. It makes a number of recommendations which we hope will allow people at the outset of a mental illness to not lose their dreams of the future, but to turn them to reality with all the individual, societal and economic benefit that will bring.

Key Recommendations

This report presents a number of recommendations that are detailed in the Section 6. However the key steps to helping young people with mental illness realise their employment and educational dreams are:

- Fund high fidelity IPS employment and education services to be provided to young people presenting to headspace centres around Australia. These services would be fully embedded and come under the governance of headspace. This could be funded from a range of current funding sources.
- Use the headspace national dataset to capture the data about an integrated model and use this to evaluate and refine the provision of these services.
- Using lessons from the scaling up and implementation of IPS at headspace centres, expand IPS services into mainstream community mental health services for all mental health consumers who wish to work or return to study.
- Develop anti-stigma campaigns targeting employers, families, young people and primary care providers to break down attitudes that imply that young people with mental illness cannot or should not work.
- Educate mental health clinicians about the importance of employment and education as a part of, not the product of, recovery. Such a program to be led by the National Centre of Excellence in Youth Mental Health.
- Through the provision of comprehensive early intervention services that address both symptomatic and functional needs, provide a viable pathway to return to employment and education.

Introduction

This report addresses disadvantage in employment and education faced by young people aged 12-25 years with mental illness. It has a specific emphasis on this age group because mental illness has its peak onset in youth, and as a consequence the normal process of vocational development is disrupted. Intervening early to address disrupted vocational development is likely to have significant individual, societal and economic benefits.

The paper begins with a brief overview of the characteristics of mental illness, the prevalence of conditions and associated costs.

The second section of the paper sets out the difficulty people with mental illness encounter at school and examines current education policy and program settings before describing possible solutions to current shortfalls.

The third section looks at disadvantage experienced in employment by people with mental illness, overcoming barriers to work and the current employment services available to people with severe mental illness. It then looks at the design issues found in employment services and offers recommendations to ameliorate the situation.

The fourth section of the report introduces and describes a variety of evidence-based employment services and defines a path to implementing these services in Australia.

The fifth section proposes a novel approach to education and employment interventions in Australia for young people with a mental illness.

Recommendations arising from the report are in Section 6 and the report is concluded in Section 7.

Why are education and employment important?

Accepted wisdom is that people with mental illness either can't or shouldn't work. This is simply not true. The former position relies on the false argument that people with mental illness in the workplace are unreliable, poor employees and possibly dangerous. The latter argument, that people with mental illness should not work, relies on the idea that work is inherently stressful, that the stress of it will lead to relapse. In turn the relapse will lead to the loss of the job, which will compound feelings of failure and poor self-esteem. In short, work for people with mental illness should be avoided. These widely held views underpin the actions of otherwise well meaning clinicians, family members and other carers and young people with mental illness themselves. They are also at least partially responsible for the rapid growth in people with mental illness being in receipt of the Disability Support Pension (DSP). Subsequently, if work is not to be a feature in the life of people with mental illness, the unspoken corollary is that there is little point in wasting too much effort on education – the foundation of career. Consequently, while there is some evidence for employment supports for people with mental illness, there is next to no evidence on which to base educational interventions.

And yet education and employment are important to people with mental illness, and in particular young people with mental illness, for all the same reasons as they are important to people in the general community who do not have mental illness. As well as providing a wage, which is a key factor in establishing independence, employment is the royal road to social inclusion. Further, the positive effects of work on mental health include an association between employment and improved quality of life and wellbeing (Marwaha et al 2008). Work is also associated with better physical health, more and better social relationships, community participation and is key to the development of a socially valued identity. Education is indispensable to vocational development in maximising the opportunities that the individual will have to enjoy meaningful and rewarding employment. Links between educational attainment and sustainable

outcomes in employment are well known (Waghorn et al 2012).

In the past, for people with mental illness, work was seen as something to be possibly engaged in only after recovery. Increasingly participation in work and education are seen as key elements of the recovery process – as important interventions for wellness in and of themselves. In this way it is similar to the changed message about injured backs in which the focus is now on a speedy return to work rather than a prolonged absence. Another way to think about this is that the onset of mental illness can be an extremely de-normalising time. People typically turn stigma in on themselves and believe all the stereotypes about mental illness apply to them – that they are other than normal. There is no intervention in all of mental health's armamentarium as powerfully normalising as the offer by someone to pay you for your labour after a competitive job selection process.

Additionally, consumers themselves report that employment and education are important. Studies tell us that unemployment is associated with worsening psychological illness and increasing social exclusion (McKee-Ryan et al 2005). People with lived experience don't need a study to tell them this. They know. Consequently, even at the outset of illness, the desire to complete education, get work and enjoy the benefits such as independent housing and social relationships outrank symptom recovery as goals (Iyer, 2012; Ramsay, 2012). Studies estimate that between 70% (Drake et al 2012) and 90% of people with mental illness want to work (Killackey 2014).

So what's the problem?

Despite wanting to work and complete education and training, people with mental illness have low levels of completion of secondary education, among the worst labour force participation rates of people with any disability, and high unemployment levels. Unemployment rates rise rapidly following the onset of mental illness (Rinaldi et al 2010), quickly followed by transition to disability pensions (Ho & Andreason, 2005). People with mental illness are the largest and fastest growing disability group in receipt of the DSP in Australia. Studies following cohorts with mental illness starting on disability pensions note that over up to 5-year follow-ups, few people transition back off a disability pension (Ho & Andreason, 2005). This accords well with data showing that in Australia the two most common exits from the DSP are death and the aged pension (Department of Social Services 2013). Given the early onset of mental illness, an individual may potentially spend more than 40 years on the DSP. This represents an avoidable personal and economic disaster. However, the system that should do most to prevent this situation, the Disability Employment system fails at this task in relation to people with mental illnesses.

Disability Employment Services are intended to provide the ongoing and proper level of support for people with severe mental illness. Yet, positive employment outcomes for people reporting a psychiatric disability in the service are far too low. It has even been suggested that people with severe mental illnesses actually do better in finding work themselves than they do with the help of disability employment services (Waghorn 2011). Contributing reasons to these poor outcomes will be discussed in Section 3.

Is there a solution?

Currently in Australia employment services use a "train and place" approach that revolves around building work readiness before entering competitive employment. This contrasts with vocational models based on the "place and train" philosophy. There has been a shift in the literature in recent years toward approaches that

> "The Strategy will help ensure that policy settings, including health, education, employment and income support systems and infrastructure are properly designed to help meet the aspirations of people with disability, and to maximise productivity across all sectors of the population wherever possible"
>
> (Commonwealth of Australia, 2011, p18).

focus less on pre-employment training and more on building work skills in the competitive labour market and real-world on-the-job training while providing concurrent supports (Drake et al 2003).

Analysing education settings as well as employment services with a view to creating more effective and supportive systems is paramount to addressing social and vocational isolation and allowing Australians with mental illness to build the base platform from which to pursue their life goals.

It is also important to look at the settings around the Disability Support Pension to ascertain whether any policy levers could be used to better reflect the needs of people suffering mental illness. This paper will look at evidence based employment interventions and disability targeted education systems in an attempt to tackle the variety of problems facing government in this sphere.

In addition there are a number of existing policies that will contribute to the solution. The Australian Government's National Disability Strategy exemplifies the push to improve employment outcomes for disabled people and should be the basis of policy settings for people suffering mental illness.

The fourth National Mental Health Plan sets out five priority areas for policy reform around social inclusion and recovery, prevention and early intervention, service access, quality improvement and innovation and accountability.

Despite the presence of some policies that may help in addressing this issue, it must be remembered that people with mental illness as a disability group have not benefited from any of the various changes in employment policies over the years. While being open to the positive potential of existing policies, in order to produce an effective and sustainable solution it may be necessary to imagine and design new policies and means of delivering services. To continue to fund systems that do not and have not worked for people with mental illness is a disservice to a population eager to work and must be seen for the wilful wastage that it is.

Reducing isolation, financial disadvantage and other problems associated with mental illness is not only vital to improving the lives of young people with mental illness but also to improving productivity and sustainability of the Australian economy and society.

"A mental health system that enables recovery, that prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community."

(Commonwealth of Australia, 2009, pii)

Section 1: The illness

This section discusses the prevalence and characteristics of mental illness in Australia, the associated costs and current treatment rates. It examines unintended effects of current Medicare arrangements for young people accessing psychological services and proposes changes to encourage and increase take-up of mental health services among adolescents through the removal of barriers to early intervention.

Prevalence and characteristics

Around half of the 16 million people in Australia aged 16-85, or 7.3 million people, will experience a mental disorder in their lifetime and around 20% or 3.2 million people suffered from a mental illness in the 12 months prior to 2007 (ABS 2007). Approximately 14% of 12-17 year olds and 27% of 18-25 year olds have mental health or substance abuse problems each year (headspace 2011). Mental health conditions and substance use disorders are responsible for 60-70% of the burden of disease for 15-24 year olds (Ibid.).

There are a number of different kinds and varying severities of mental illness. Severe and enduring mental illness usually refers to conditions such as schizophrenia, bi-polar affective disorder, severe depression and anxiety (Mental Illness Fellowship of Victoria 2013). Despite the serious nature of these disorders and the massive impact they can have on a person's life they can be managed and controlled through the use of medication, therapy, self-care routines, support networks and clinical care. People with severe mental illness are still capable of achieving their goals of participating fully in society and living fulfilling lives.

There are several key characteristics of these illnesses that should be taken into consideration when formulating effective mental health policies. The onset of most psychiatric disabilities occurs during adolescence (McGorry et al 2011). This has repercussions for a person and their engagement with their education. It also means the period of transition between formal education and employment can be substantially more difficult for people suffering from mental illness.

Most mental illness is episodic. Someone suffering from a severe psychiatric disorder may experience periods of significant disruption and illness that make work seem like a distant dream but there are also times when the person will feel relatively unhindered. Conditions can be manageable and with treatment and support many people will be able to reduce the length of periods of sickness and extend time between episodes of the illness (Mental Illness Fellowship of Victoria 2013).

Commonly associated with a variety of mental illnesses are negative symptoms such as a lack of motivation, a lack of enjoyment and low levels of confidence (Mental Illness Fellowship of Victoria 2013). These can be crippling but avoiding social isolation and providing proper care is vital to ameliorate the worst effects of mental illness. Support networks such as friends and family, encouragement, good clinical treatment as well as fulfilling activities such as employment or further education can be incredibly valuable and help overcome these negative symptoms. However, even the best treatment can still sometimes not be enough to completely stop symptoms such as hallucinations (Mental Illness Fellowship of Victoria 2013).

Costs associated with mental illness

Mental disorders represent the largest cause of disability in Australia and account for 13.1% of the nation's burden of disease (Commonwealth of Australia 2012). This leads to an estimated $20 billion cost to the economy each year in lost productivity and labour force participation (Ibid.).

Annual costs of psychosis are significant. The 2010 Australian National Survey of Psychosis found a cost to society of $77,297 per affected person per year. This was made up of $40,941 in lost productivity, $21,714 in health sector costs and $14 642 in other sector costs. According to the report, health sector costs are 3.9 times higher for people with psychosis than for the general population. It also pointed to a cost of $4.91 billion per annum to the Australian society and a $3.52 billion annual bill for government (Neil et al 2014). This represented minimal change from the survey done in the year 2000 (Ibid.). Increases in cost per person for ambulatory care, non-government services and pharmaceuticals were offset by a halving of inpatient costs and an 84.6% decrease in costs associated with crisis accommodation (Ibid.).

Productivity losses remained fairly stable over the previous decade illustrating the size and consistent nature of employment disadvantage faced by people with a mental illness. The lack of improvement in employment outcomes and productivity losses is especially worrying considering significant changes in policy since the first survey. There was a reduction in national unemployment, several national mental health strategies and significant work on the disability employment services (Waghorn et al 2012).

Given the lack of improvement in sustainable employment outcomes for people with mental illness it is important to look at improvements to vocational assistance. Tackling barriers to competitive employment is paramount both for the health of individuals and the budget bottom line.

Treatment rates and disease burden

Mental illness represents the third largest disease burden in Australia (Waghorn & Lloyd 2005). It trails cardiovascular diseases and cancer in terms of morbidity and mortality. In terms of morbidity, mental illness is the leading burden of disease in Australia (Ibid.).

Anxiety, depression and substance use represent a leading disease burden but evidence points to a lack of treatment. Even though it is well known untreated disorders incur major economic costs and personal anguish, only a third of people with these illnesses access treatment (Whiteford et al 2014).

This is despite a major policy shift in 2006 that saw the creation of the Better Access Medicare Benefits Schedule that allowed psychologists, some social workers and occupational therapists to claim Medicare rebates for patients referred by GPs. This has seen an increase in treatment rates for all mental disorders from 37% in 2006-07 to 46% in 2009-10 an increase achieved in no other country (Ibid.). People being treated using Better Access has risen from 10.1% in 2006-7 to 27.6% in 2009-10 (Ibid.). While this represents a significant improvement it is concerning that the majority of people suffering mental health problems are still not seeking treatment.

Policy Implications

Early intervention is a key plank of the Australian Government's National Mental Health Plan. Its positive effects are numerous and well documented. This includes mounting evidence that specialised early intervention mental health services can provide increased employment. However, according to the evaluation of the Better Access scheme young people are still using psychological services at a lower rate than the rest of the population. While this has improved since the scheme was introduced there is still work to be done.

To give people the best chance to overcome and manage their illness and be self-reliant, we should improve access to psychological and psychiatric services as early in life as possible. One barrier that is particularly problematic for young people is the significant Medicare co-payment required to use these services. Whilst there is currently bulk billing available for some services, the rates at which bulk billing occurs are vastly different between GPs and mental healthcare providers. General Practitioners providing mental health care consultations bulk bill 90.2% of the time while the average co-payment is $18.58 (Department of Health and Ageing 2007). This compares to psychological consultations, which are bulk billed 25.9% of the time and attract an average co-payment of $27.97 (Ibid.). Psychiatrists bulk bill 29.9% of the time and on average charge a co-payment of $65.10 (Ibid.).

While co-payments might not seem large and prohibitive, a young person with no or a very low income may be put off even by the smallest charge. Without support from parents the payment for services is a barrier to accessing treatment for young people. Two mechanisms could address this issue. The first is to require bulk billing of relevant services to eliminate the cost to the target user group. The second is to increase

payments to service providers as compensation for the elimination of the co-payment, with the loss of earnings due to the abolition of the co-payment for this age group overcome by the subsequent increase in usage.

Recommendation

Create a new Medicare benefit class for people under the age of 25 receiving treatment that either:

- requires bulk billing; or
- provides psychologists and psychiatrists with a slightly higher payment in exchange for getting rid of co-payments.

Section 2: Education and mental illness

This section of the report sets out the disadvantage people with mental illness face at school, which has obvious implications for employment later in life. The report looks at the current education policy framework by describing key Commonwealth initiatives and several programs in New South Wales and Victoria. The paper then briefly describes specialist mental health staff in other States and Territories before suggesting recommendations to improve educational attainment for people with mental illness.

Disadvantage at school

Disadvantage is keenly felt in the area of educational achievement. The vast majority of mental illness has its onset in adolescence and early adulthood. Often this can derail a young person's education leading to a competitive disadvantage in seeking employment (McGorry et al 2011). Each year around one in four young Australians experience a diagnosable mental illness (Ibid). Among people aged 15-25 years, mental-health and substance-use disorders account for over 50% of the burden of disease (Ibid). This along with the fact 75% of these disorders will have developed by the age of 25 illustrates the importance of early intervention (Ibid). Psychotic disorders typically have their onset between the ages of 10 and 30 which is a critical time in terms of completing formal education and setting up career pathways (Waghorn & Lloyd 2005).

The 2009 Australian Bureau of Statistics (ABS) Survey of Education and Training found 38% of 20-24 year olds with a mental illness had not completed Year 12 and had no plans for further education compared to 25% of people with other disabilities or long term health conditions (ABS 2009).

In 2003 63% of people with psychological disability reported no post-school educational attainment compared to just over half of people with physical disabilities (ABS 2003).

Ill health and disability were reported as barriers to educational attainment for 7% of 15-24 year olds with a mental illness or nervous conditions compared to 3% for other long-term illnesses (ABS 2009).

In addition a survey of people with psychotic disorders found that 18.4% had difficulty reading or writing and only 31.9% had completed high school (Waghorn et al 2012). The study found links between educational attainment and employment status. It illustrated that engagement of disadvantaged students is vital to improving work prospects into the future. People with severe or very severe mental illness were more than twice as likely to be employed if they held a high school qualification (Ibid). The link was even more obvious among people with illnesses that had a lesser impact on their functioning. People with good to very good global functioning experienced a jump from 6.6% employed to 28.5% employed if they had a high school qualification or better (Ibid).

levels of high school completion for people with mental illness are between 32% and 62% depending on illness. This compares to a Year 12 completion rate of 78% for all 20-24 year olds in 2010. (ABS 2011)

Thus levels of high school completion for people with mental illness are between 32% and 62% depending on illness. This compares to a Year 12 completion rate of 78% for all 20-24 year olds in 2010 (ABS 2011). Besides highlighting the source of their competitive disadvantage with respect to employment, these figures also illustrate that while a variety of policies are aimed at improving educational attainment and engagement for people with a mental illness, there is clearly a long way to go.

Education policy framework:

School education is a state and federal responsibility. The Commonwealth Government provides funding to

both public and private schools predominately through State Governments. Each school also has significant autonomy as to how programs are delivered.

All governments in Australia are facing increasing fiscal pressures due to the growth of expenditure exceeding the growth in revenue. In addition the vertical fiscal imbalance means that States and Territories are under significant pressure to fund expensive education initiatives, especially without the financial support of the Commonwealth.

In addition, there are a variety of Commonwealth funded programs aimed at engaging adolescents in education. Each State also has individual strategies aimed at ensuring disadvantaged students have the supports they need to access a good education.

This section will set out the Commonwealth programs and look at some of the State initiatives aimed at engaging adolescents with mental illness and helping them get a high quality education.

Important Commonwealth education policy initiatives

School funding

School funding has recently undergone sweeping changes. The new Better Schools agreement is based on a report chaired by David Gonski and provides resources based on schools' level of disadvantage. The Report's goal was to provide equity in schooling so all children have access to high quality education regardless of where they live and what school they attend.

The Commonwealth gives schools money based on an amount it calculates is needed to educate a child each year. The Schooling Resourcing Standard (SRS) sets base funding amounts with additional loadings provided based on students and schools that need more support.

The previous Australian Government committed itself to $3.1 billion over the forward estimates and an additional $8.3 billion in years five and six (ABC 2013). The current Government has indicated it will honour the first four years of the funding agreement but has not disclosed its position for additional funding past the forward estimates (Ibid.).

National Partnership on Youth Attainment and Transitions (January 2010 – December 2013)

The Council of Australian Governments (COAG) agreed on a national partnership to improve educational attainment and better the transition between school and further education, training or employment. The agreement has a particular focus on 15-24 year olds and young people at risk of disengagement from school.

The goals of the National Partnership are:

- To lift the Year 12 or equivalent attainment rate to 90% by 2015
- To provide an education entitlement to young people
- To better engage young people with education
- To help 15-24 year olds transition from schooling to further education or employment
- To align Commonwealth, State and Territory programs related to young people

The National Partnership has five elements:

- Individualised support for at risk young people through the Youth Connections program
- School, business and community partnership brokers
- Maximising Engagement, attainment and successful transitions (State and Territory government responsibility)
- National career development
- The Compact with Young Australians

Youth Connections

Youth connections is a program aimed at helping young people overcome the barriers that make it difficult to stay in or return to school. The Government has allocated $286.8 million over four years to this program (Department of Education 2011). The program is available to young people at risk of disengaging or who have already disengaged from school as well as their family. The program is delivered through individualised case management with flexible one-to-one services to help keep adolescents engaged with education or further training. A Youth Connections provider can also help a young person reconnect with family, find a mentor and put a young person in contact with mental health, literacy and numeracy services.

In 2010 more than 21,000 young people received individual support through the program including nearly 5,000 clients (23%) with a suspected or diagnosed mental health issue (Submission 62, 2011).

School Business Community Partnership Brokers

This program was funded with $182.9 million over four years (Department of Education 2011). It aims to support and create partnerships between schools, business, community organisations and families. This is in an attempt to improve transition outcomes for young people leaving school.

Compact with Young Australians

As part of the National Partnership agreed to at COAG, young people and particularly early school leavers are targeted by the Compact with Young Australians. The compact includes:

- A requirement to stay in school until at least Year 10 and participate full-time (at least 25 hours a week) in education or training until aged 17.
- An entitlement to an education or training place for all 15-24 year olds. This is particularly focused on achieving Year 12 or equivalent outcomes.
- Increased participation requirements for people under 21 years of age without Year 12 qualifications who are in receipt of government benefits like Youth Allowance.

National Disability Insurance Scheme

The NDIS will provide funding for supports that enable eligible participants to attend school education. The money will aid people with severe mental illness engage in a range of activities.

The funding will help provide a range of supports including (Commonwealth of Australia 2014):

- Assisting students at school with self-care needs
- Specialised support to transition between schools or from school to tertiary education
- Specialist transport required due to disability
- Equipment required due to disability such as wheelchair or personal communication device

This is in addition to supports that are already funded through the education system. These include (Ibid.):

- Learning assistance or teachers aids
- Adjustments to school curriculum
- Supervision to address behavioural issues and school participation

More Support for Students with a Disability

The Australian Government has provided $300 million over three years, which is due to end in 2014 (Department of Education 2013). This money is for support services for students with a disability. All eight State education departments and 16 non-government education authorities have agreed to implement plans to provide supports such as:

- Health or allied health specialists within a school
- Individual curriculum differentiation to better engage people with a disability or learning difficulty
- Technology that helps students to learn in the classroom

Each authority sets out details of what is being provided in progress reports (Department of Education 2013).

Centrelink

Centrelink provides payments to help young people between the ages of 15 and 24 continue education and training such as Youth Allowance, ABSTUDY and the Early Study Payment. The agency also provides information on programs aimed at education and training such as Youth Connections and the Australian Apprenticeships Access Program.

Australian Apprenticeships

The Australian Apprenticeships Access Program is aimed at vulnerable job seekers and can help people access apprenticeships, find employment or get into further training. It is specifically targeted at early school leavers, people who are homeless and mature age job seekers (Department of Industry 2013). The program provides pre-vocational training, job search support and post-placement support (Department of Industry 2013).

Australian apprentices with a disability can also access additional assistance under the Australian Apprenticeships Incentives Program. The supports include Disabled Australian Apprentice Wage Support which is paid to employers and mentoring/tutorial services (Department of Industry 2013).

There are also additional supports available through JobAccess, Job Services Australia or Disability Employment Services. Particularly through the Employment Assistance Fund, job seekers with a mental illness can access money to buy work related services (Department of Industry 2013).

The Australian Apprenticeship Mentoring package consists of the Australian Apprenticeships Mentoring program and the Australian Apprenticeships Advisers program.

The Mentoring program supports around 10,000 apprentices with around 330 mentors each year. This is targeted at industries with skills shortages and apprentices facing barriers to participation such as people with a disability. The program is designed to aid in the retention of apprentices at risk of dropping out and is funded until 2015.

The Advisors program was part of the 2011 budget and was in response to the Apprenticeships for the 21st century expert panel report. Twenty-one million dollars was provided over a two year period (2011-13). It is aimed at providing advice and information to people considering an apprenticeship (Department of Industry 2013). No further projects will be funded under this program.

Skills for Education and Employment (SEE)

Previously known as the Language, Literacy and Numeracy Program, the SEE program is aimed at improving the language, literacy and numeracy of job seekers who are finding it hard to obtain employment. Job seekers are referred by the Department of Human Services (Centrelink), Job Services Australia providers (JSA), Disability Employment Service providers (DES) and Remote Jobs and Community program providers. Job seekers must be 15-64 years old, not a full-time student, registered with an employment service provider and receiving a social security benefit (Department of Human Services 2014). People in the program can access up to 800 hours of free training delivered in full-time or part-time hours (Department of Industry 2013).

The program is capped and aims to achieve 30,000 new commencements in 2014-15 and is funded to achieve at least that number of new commencements each year (Department of Industry 2013).

Mindmatters

Mindmatters is a program with a whole-of-school approach aimed at improving the school environment, implementing curriculum materials aimed at mental health awareness, increasing student resilience and teacher development for mental health promotion in schools (URBIS 2011).

National School Chaplaincy Program

This program helps schools access a chaplain or pastoral care worker to support student wellbeing. Funds are provided to both government and non-government schools to establish or enhance chaplaincy services (Submission 62, 2011).

State and Territory education initiatives

Each State and Territory has different policies aimed at engaging young people with their education and keeping adolescents at school. It is outside the scope of this report to analyse each policy individually but a snapshot of initiatives in New South Wales and Victoria will illustrate the current landscape.

New South Wales

In NSW there is a wide range of student welfare services available within and to schools including (URBIS 2011):

- Students with a disability can access supports in their school though specialist services. There is assistance provided through the Learning Support Teams which help teachers to address the needs of students with a disability, learning difficulty or behavioural disorder.
- Peer mediation aimed at reducing violence, truancy and vandalism in schools.
- The Child Wellbeing Unit within the Department of Education. This is comprised of three teams which include seven Assessment Officers and a Child Wellbeing Consultant (senior psychologist).
- The curriculum and staffing model is designed so students are taught by one or a small number of teachers. Additional support is provided through the Integration Funding Support program. Money from this program is designated for additional teacher time, training and school learning support officer time.
- School learning support team. This team is made up of a team facilitator, school counsellor, teacher representatives and specialist personnel such as carers or English-as-a-second-language teachers.
- Student learning and support coordinators. These specialist teachers provide support for classroom teachers and students.
- Learning assistance program which helps students from Kindergarten to Year 12 having difficulty with literacy, numeracy or language regardless of the cause.

School-Link

This program was launched in 1999 and aims to improve the mental health of students (URBIS 2011). The NSW Department of Education in collaboration with the NSW Department of Health provide a framework for mental health services and schools to promote mental health, facilitate early identification and assist students suffering from mental illness (Ibid.). There are three main areas:

- Strengthening formal and informal links between mental health services and schools.
- Training mental health workers and school counsellors
- Supporting implementation of mental health initiatives including prevention and early intervention.

School Counsellors in NSW

School counsellors in NSW schools have qualifications in teaching and psychology. They are school-based and provide counselling and psychological assessment services to students. Figures from 2009 show there are 790.8 full time school counsellor positions in the NSW public school system (Ibid.). Counsellor positions are allocated based on need, numbers of students with a disability and socio-economic disadvantage and are supervised by District Guidance Officers (Ibid.).

In NSW, there is an average counsellor/student ratio of 1:1,050 and reports have indicated counsellors spend the bulk of their time doing assessment with little time for preventative and support services (Ibid.). The NSW Commission for Children and Young People recommended the ratio be improved to 1:500 (Ibid.).

Victoria

A report by the Auditor General in 2012 identified that 1 in 5 students require assistance at school (Victorian Auditor General 2012). Victoria has a range of policies aimed at supporting the welfare of students. These include:

- Student Support Services program. This program cost $66 million in 2011 (Victorian Auditor General 2012). Student Support Services Officers (SSSO) help through early intervention with students at risk of disengaging, develop capacity within schools to deal with students requiring additional support, aid in overcoming learning barriers and respond to critical incidents involving students and teachers. The SSSOs have qualifications ranging from psychologists and social workers to speech pathologists and guidance officers. The Victorian Education Department estimates one in five students will need to access the Student Support Services program at some stage in their schooling however in 2011 there were only 627 SSSOs and 540,000 students in Victorian government schools (Ibid.). This equates to a ratio of one SSSO for every 172 students who need access to the program or one SSSO for every two schools (Ibid.).
- Student Welfare Coordinators. This is aimed at addressing truancy, bullying, drug use and depression (URBIS 2011). Schools administer funding provided by the State Government for this initiative.
- Primary Welfare Officers. This position is filled by either an existing staff member with health, social work or mental health experience. The Primary Welfare Officer aims to foster a better environment at schools and to support students at risk of disengagement.

Victorian Certificate Applied Learning (VCAL)

VCAL offers an important option for students at risk of disengagement. This is reflected in the student cohort enrolled having characteristics identified with groups at risk of disengagement (Victorian Auditor General 2012).

In 2011 there were 13,858 public school students enrolled in VCAL representing a 60% increase since 2006 (Victorian Auditor General 2012). According to the Victorian Auditor General's 2012 report, in 2010 87% of intermediate or senior students enrolled in the program went into work or further training (Victorian Auditor General 2012). However, recent cuts to the program have affected the feasibility of students trying to attain a secondary school certificate through VCAL (Victorian Auditor General 2012). Completing senior or intermediate VCAL provides an alternative senior secondary school certificate.

Education programs for students using mental health services

There are a several schools students can be referred to once they are involved in mental health services. The student remains enrolled at their mainstream school but can receive additional assistance through supported education settings available at the following schools:

- Travencore School
- Austin School
- Avenues Education
- Baltara

These schools provide inpatient school support for students undergoing treatment for mental illness.

Programs such as those found at the Travencore School in Victoria offer important specialised mental health programs for students receiving treatment for psychiatric conditions.

Other State and Territory specialist mental health staff

For a summary of all relevant policies in other States and Territories refer to the Psychological and Emotional Wellbeing needs of Children and Young People: Models of Effective Practice in Educational Settings report produced by URBIS for the NSW Department of Education and Communities (URBIS 2011). Here is a quick snapshot:

South Australian wellbeing staff:
- Guidance officers
- School counsellors. Teachers employed in primary and secondary schools many of whom have no formal training in psychology.

Queensland wellbeing staff:
- Guidance officers
- Chaplains
- Community education counsellors
- Regional behavioural management staff

Western Australia wellbeing staff:
- School psychologists
- Pastoral care provided by teaching staff
- School chaplaincy program

Australian Capital Territory wellbeing staff:
- School counsellors with qualifications in psychology and teaching
- Student management consultants

Northern Territory wellbeing staff:
- School psychologists – registered with NT Psychologist's registration Board
- School Counsellors

Tasmania:
- School psychologists – must hold teaching qualifications and be registered

Policy Implications and recommendations

There are clear links between educational attainment and success in the workforce. School offers a great opportunity for students' needs and issues such as mental illness to be recognised and addressed. While there are a variety of different policies and services available in each jurisdiction, students with mental illness are still facing serious barriers in their education.

Resourcing education programs for young people with mental illness is an issue across Australia. While the need for such services is clearly understood there appears to be a lack of consensus or evidence around which programs are the most effective and where funding should be aimed.

Effectiveness of selected policies and guidance to support students with special learning needs

Area of policy/guidance	Comprehensive	Well understood by schools and regions	Consistently implemented by schools and regions
Applying for Program for Students with Disabilities funding	✔	✔	✔
Accessing student support services	✔	✔	✔
Establishing student support groups and outlining members roles and responsibilities	✔	✘	✘
Developing and using individual learning plans	✔	✘	✘
Full time enrolment requirements	✔	✘	✘
Complaints	✔	✘	✘
Restraint and seclusion practices	✘	✘	✘
Parent payment for additional support	✘	✘	✘

Source Victorian Auditor-General's Office

Programs such as those found at the Travencore School in Victoria offer important specialised mental health programs for students receiving treatment for psychiatric conditions. These programs are vital and funding them sufficiently is important. However, they require students to already be engaged in mental health services and treatment. This means students at risk of disengagement, suffering from mental health disorders that are yet to need or seek treatment cannot be serviced through these schools.

There is also a gap between policy and practice. This is best illustrated by the graphic above from the Victorian Auditor General.

Bridging the gap between policy and practice is vital if changes to the system are to have the desired effect.

Recommendations

- Develop a nationally consistent approach to funding and supporting programs aimed at engagement and wellbeing to address inadequate funding and reduce differences between jurisdictions in policy and practice.
- Improve staff to student ratios in important programs such as Student Support Services Officers through increased funding attached to disadvantaged students and schools.
- Improve funding structures for alternative education settings which deal with students who are receiving clinical treatment.
- Develop supported education policies in mainstream settings for students before they are referred to mental health services with funding structures which allow for growth.
- Continue to work with schools, students and parents to promote mental health literacy and enhance resilience and support teachers to recognise issues and refer students with mental illness to someone better placed to treat the condition.

Section 3: Employment and people with mental illness

This section of the report describes levels of disadvantage encountered by people with mental illness in relation to employment. The report then looks at overcoming various barriers to employment and describes current support settings. After a thorough description of current employment services the report will move to a discussion of employment outcome results and policy initiatives aimed at improvements for people with mental illness using the services.

Employment Disadvantage

There is a growing body of evidence that suggests current policy settings are not addressing employment disadvantage among young people facing significant vocational barriers due to psychiatric disorders.

The labour force characteristics are alarming. In 2003 the Australian Bureau of Statistics reported that people with a psychological disability had the lowest participation rate of any disability group at 28% and the highest unemployment rate of all groups at 19% (ABS 2005).

Australian Bureau of Statistics data from 2009 reported 369 600 people with a psychological disability (ABS 2012). This made up 17% of all people with a disability. In 2009 29.2% of people suffering from a psychological disability were participating in the workforce and 18.9% of those were unemployed (Ibid.). This does not compare well to other disability groups. People with brain damage, head injury or stroke (155,600) made up a smaller proportion of the total disabled population in Australia but report a higher labour force participation rate (35.6%) and a lower unemployment rate (15.3%) (Ibid.). People with a physical disability (1,546,000) were even better off with 49.7% playing some part in the work force and 7.5% unemployed (Ibid.). The labour force participation rate for people without a disability in 2009 was 82.8% with an unemployment rate of 5.1% (Ibid.).

In terms of severe mental health problems, a 2012 Australian study found only 22.4% of people with psychotic disorders were employed part or full time (Waghorn et al 2012). This study showed that there has been no real change over a period of 12 years since a similar study in 1998 found an employment rate of 21.1% among Australians with psychotic illness (Waghorn et al 2004). This compares to a report in the UK that found 27% of survey participants with a psychotic disorder were employed (Ibid). In the USA the results were worse with 20.5-22.5% of people with schizophrenia employed (Ibid). While psychosis is much rarer than conditions such as anxiety, its effects are profound. In 1998 75.2% of householders with psychosis were unemployed and not looking for work, 21.1% had jobs, and 3.7% were still searching (Ibid.). This emphasises the lack of change in employment outcomes over the last decade and a half even as program and labour market conditions have shifted. Rinaldi and colleagues have documented that a rise in unemployment predates accessing treatment and rises rapidly through the early course of illness (Rinaldi et al 2010). This again emphaises the need to address vocational issues early in the course of illness.

This study showed that there has been no real change over a period of 12 years since a similar study in 1998 found an employment rate of 21.1% among Australians with psychotic illness

The Reserve Bank of Australia (RBA) recently released a report looking at economic disadvantage and unemployment. The report notes that the impacts of long term unemployment are "a depreciation of skills, reduction of social networks and adverse consequences in terms of health outcomes and life satisfaction, all of which impede the task of finding employment" (Cunningham et al 2014 p29). Given that poor work-related skills and a lack of social networks

it is well known that unemployment for members of the general population is stressful, associated with poorer physical and mental health and family and relationship breakdown. It is a strange form of bigotry that assumes that this would not also be the case for unemployed people with mental illness who wish to work

are characteristics of people suffering from mental illness, this is likely to multiply the difficulty in obtaining employment for people with psychiatric conditions who are long-term unemployed. Further, Alvarez-Jimenez and colleagues have shown that making a functional recovery – that is getting back to school and work - early in the course of illness is actually more predictive of long term outcome than making an early symptomatic recovery (Alvarez-Jimenez et al 2012) .

Overcoming barriers faced by people with mental illness

Entering the workforce offers the ability to build financial independence and benefit from social inclusion. It is therefore vital that the proper support systems are in place to help people suffering mental illness get back to work.

There are a variety of barriers separating people with mental illness from the labour market. The most recent National Survey of Psychosis asked people outside the labour market their reasons for not looking for work. Responses were not mutually exclusive. The most common answers were "own ill health or physical disability" (80.1%), "not wanting to work" (31.9%), "lacks necessary schooling, training, skills or experience" (24.5%) and "welfare payment/pension may be affected" (23%). A further 9% of people with psychosis not looking for work said having to care for children was the reason (Waghorn et al 2012).

There are significant other barriers to employment. Perceptions among health professionals that patients cannot benefit from work can act as a powerful disabling influence on people with mental illness. The Mental Illness Fellowship's research shows often those closest to the person suffering from mental illness worry about the negative effects returning to work might have on their loved one (Mental Illness Fellowship Victoria 2013). This coupled with advice from clinicians that full-time work will be too stressful and will never be achieved is a barrier that could be broken down by better understanding. For example it is well known that unemployment for members of the general population is stressful, associated with poorer physical and mental health and family and relationship breakdown. It is a strange form of bigotry that assumes that this would not also be the case for unemployed people with mental illness who wish to work.

People suffering mental illness often face significant stigma and discrimination in the workplace and in the general community. In fact, anticipation of discrimination has been shown to deter two thirds of people with mental illness from applying for work (Thornicroft et al 2009). Countering stigmatising attitudes can be difficult and is an ongoing challenge. Efforts around mental health awareness are important in tackling this barrier. A report released in 2008 examining employer attitudes says "it would be helpful to educate the community that mental illness is not a person's choice or 'fault'; mental illness is a medical condition that is manageable and can be treated" (DEEWR 2008 p17). Employment specialists can also play an important role. Strategic disclosure to employers and educating the workforce and wider community can counter stigma (Waghorn & Lloyd 2005). Waterhouse looked at issues around disclosure from the employer's perspective and concluded non-disclosure is an issue that makes the job of managers more difficult and employer understandings of what mental illness is problematic (Waterhouse et al 2010). Improving support structures and employment opportunities will help people with mental illness demonstrate their work potential and overcome commonly held misconceptions.

A lack of coordination between treatment and vocational rehabilitation interventions can act as another barrier to employment goals (Waghorn and Lloyd 2005). Changes in medication and dosage can produce additional difficulties in finding and keeping work as the side effects of antipsychotic, and anti-depressant medications can cause challenges (Rutman 1994).

The current state-federal funding arrangements and administrative structures spanning several departments create additional barriers to employment for people suffering mental illness. Accessing employment services, benefit payments, healthcare and educational services requires coordination across various agencies and levels of government. A young person with mental illness, despite being the person least capable, is then

responsible for managing all these services across various agencies. Integrating employment services with clinical treatment teams and including counselling around benefits and education opportunities could help improve outcomes. These are key elements of the Individual Placement and Support method of employment support which is discussed further in Section 4, below.

Disability Support Pension

Welfare payments to people with a disability accounted for $14.9 billion last financial year (Commonwealth of Australia 2013-14). This was paid to 821,738 people. In 2013, those suffering from psychological and psychiatric illness made up the largest category receiving benefits (256,380 people, or 31.2%) and accounted for 17,348 or 31.5% of successful new DSP applicants, up from 24% in 2006 (Department of Social Services 2013). The proportion of people with mental health problems receiving the disability payment has been increasing since 2001 and in 2011 for the first time surpassed those with musculo-skeletal and connective tissue conditions as the main category of DSP recipients. As mentioned research has shown a rapid progression of young people with mental illness onto disability pensions (Ho and Andreason)

In 2008-09 64.5% of applications for disability payments were successful. By 2012-13 the rate at which people were granted the DSP had fallen to 43.3% (Department of Social Services 2013). This is likely to be related to the introduction of new assessment procedures and revised impairment tables in 2011.

More than 91% of DSP recipients said they had earned no money in the fortnight before the 28th of June 2013 (Department of Social Services 2013).

Integrating employment services with clinical treatment teams and including counselling around benefits and education opportunities could help improve outcomes

Basic conditions of eligibility for DSP (Department of Human Services 2014):

- Over 16 but under the aged pension age
- Physical, intellectual or psychiatric condition assessed at 20 points or higher on impairment tables and as a result the person must be unable to work 15 hours or more per week for the next two years.
- The person must also, due to their condition, not be able to undertake training to build skills necessary to work.

The maximum basic rates for the DSP are as follows (Department of Human Services 2014):

- Single aged under 18 living at home receives $345 per fortnight (independent $532.60 per fortnight)
- Single aged 18-20 dependent $391 per fortnight (independent $532.60 per fortnight)
- Single aged over 21 receives $751.70 per fortnight
- A member of a couple receives $566.60 each per fortnight

Payments are subject to an income test (Department of Human Services 2014). A person can earn up to $156 per fortnight without their payments being affected. A single person's benefit will reduce to zero dollars if they earn $1,810.20 per fortnight (Ibid.). An independent person aged 16-20 can earn up to $1,251.80 per fortnight before their pension is reduced to zero (Ibid.).

There is an assets test on DSP recipients however it does not take the family home into consideration (Ibid.). If a person with a home has assets above $196,750 then for every $1000 of assets they have above this amount their pension is reduced by $1.50 per fortnight. The level for single non-homeowners is $339,250.

DSP recipients can work up to 30 hours each week and continue to receive a part pension as long as they still meet the income test requirements (Ibid.). If a person works more than 30 hour per week their pension will be stopped but can be restarted if they reduce their workload within two years (Ibid.).

There are participation requirements for DSP recipients under 35 who are assessed as being capable of some work, study or volunteering (Ibid.). Recipients assessed as having a work capacity of 8 or more hours per week and are not working must attend regular participation interviews with Centrelink to develop a plan setting

making a functional recovery – that is getting back to school and work - early in the course of illness is actually more predictive of long term outcome than making an early symptomatic recovery

out activities to help the person get involved in the community (Ibid.). The person must meet with Centrelink every three months after the first interview and after 18 months the meetings become six monthly (Ibid.). If a person is working at an Australian Disability Enterprise, in the Supported Wage System or has a dependent child under 6 years of age they are exempt (Ibid.).

At the participation interviews information is provided to DSP recipients on the impact of employment on payments and the programs available to find work. They also talk about community activities and volunteering. The person develops a participation plan with Centrelink based on their specific circumstances.

Targeted Community Care (Mental Health) Program

The Targeted Community Care Program (TCC) is made up of three initiatives. They are the Personal Helpers and Mentors program, Mental Health Respite Carer Support and Family Mental Health Services. The objective of the TCC program is to provide community mental health initiatives aimed at supporting people with mental illness, their families and carers (FAHCSIA 2012).

Personal Helpers and Mentors (PhaMs)

In 2011-12 $82.5 million was allocated to 175 PHaMs services (Ibid.). There was also an additional $154 million over five years to employ an additional 425 PHaMs workers nationally (Ibid.).

This program provides one on one assistance to people with severe mental illness aged over 16 (Ibid.). It is aimed at overcoming social isolation, increasing community connectedness and helping people achieve personal goals and manage everyday tasks (Ibid.).

Mental Health Respite: Carer Support (MHR:CS)

The 2011-12 budget provided $50.3 million for 190 existing MHR:CS providers (Ibid.). There was also $54.3 million provided in the budget over five years to give around 1,100 families and carers access to support services (Ibid.).

The program provides flexible respite services for carers of people with severe mental illness or an intellectual disability. This is aimed at supplementary care arrangements to assist families and carers in their roles. Aside from carer support, services can include counselling, advocacy and mental health education.

Family Mental Health Support Services (FMHSS)

The 2011-12 budget allocated $15.9 million for existing FMHSS services and an extra $61 million over five years to establish 40 new FMHSS services (Ibid.).

The service provides early intervention and support to help families with children suffering mental illness. The services are aimed at reducing the stress associated with supporting a child with mental illness and recognise the integral role strong supportive families play in an individual's recovery.

JobAccess

JobAccess is a Commonwealth Government initiative to support the employment of people with a disability. The website provides a comprehensive list of services and programs for people with disabilities. This includes information for employers about mental illness, information for job seekers ranging from health professionals, accommodation, and mentoring as well as workplace mental health programs.

Disability Employment Services (DES) and Job Services Australia (JSA):

The following section will describe the DES and JSA systems including assessment processes used to classify job seekers into the most appropriate service, the performance tools used to evaluate services and the funding structures.

Employment services in Australia predominately use a train then place model. Job Services Australia providers predominately work with less disadvantaged job seekers and Disability Employment Services assist people who face larger and more numerous barriers to the labour market.

Both DES and JSA operate in a quasi-market. For-profit and not-for-profit organisations are contracted by the federal government to supply employment services. These contracts set out performance standards, rules for the provision of vocational support and conditions on payment for service. The Department of Social Services administers DES and the Department of Employment takes care of JSA.

Job Services Australia overview

Around 700,000 Australians receive employment services through the JSA at any point in time (DEEWR 2012). Upon the establishment of JSA in 2009 the federal government committed more than $6 billion over four years (Commonwealth of Australia 2012-13). There are more than 100 contracted providers across more than 2000 sites Australia wide (Jobs Australia 2013).

JSA is split into four streams of support. Stream one is for people who are relatively close to the employment market with clients facing progressively more barriers the higher the stream they are placed into.

Disadvantaged job seekers in the JSA system are placed into stream two, three and four. Stream four is designed for people with a disability and or significant social barriers while stream three is for other people at high risk of long-term unemployment.

JSA provides time-unlimited support in the job search but limits assistance to six months at work.

JSA providers work with job seekers to understand employment goals and skill levels in order to develop an Employment Pathway Plan. This details the training and support provided and sets out agreed activities the job seeker will undertake to tackle their individual barriers to employment. Changes in a job seeker's circumstances are discussed with employment specialists and assessment tools used to ascertain whether the client needs more help and whether they need to be moved to a stream offering greater assistance. Any non-compliance is reported by the JSA provider to Centrelink.

The Employment Pathway Fund is a highly flexible resource used by JSA providers to buy things that the job seeker needs. This includes paying for training courses, transport costs, work clothing and other items to assist in overcoming barriers to employment.

The Work Experience Phase is a period during which eligible job seekers in streams one to four must undertake work experience. This is in an attempt to help the long term unemployed gain work skills to move the job seeker closer to the employment market.

Disability Employment Service overview

At November 2010 there were 143,983 people enrolled with a DES provider which were split relatively equally over the two programs offered DES-DMS and DES-ESS (DEEWR 2012). The Commonwealth Government is

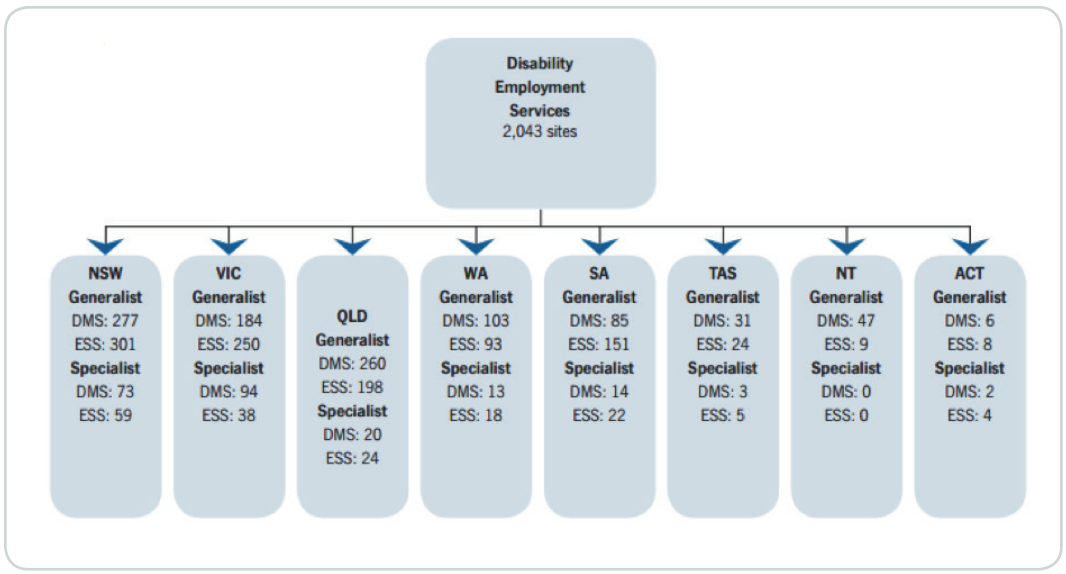

Figure 1: DES provider sites (Reproduced from Evaluation of Disability Employment Service 2012 by DEEWR)

expected to spend more than $3.2 billion over the four years from 2012-13 on the program (DEEWR 2012-13). Around 31% of DES participants have a psychiatric disability (DEEWR 2012). Most people in DES are on the Newstart benefit (Ibid.).

At the end of November 2010 there were 221 DES providers across 2,043 sites Australia-wide. This included 66 DMS providers and 207 ESS providers. Providers often offer more than one service.

DES has three different streams of services. Ranging from least intensive to most intensive - Disability Management Service (DMS), Employment Support Service (ESS) Funding Level one and Employment Support Service Funding Level two. DMS provides assistance in obtaining employment while ESS includes ongoing support to find, get and maintain work. Payments for service and outcomes increase as services are intensified.

Both types of employment assistance, DES-DMS and DES-ESS, provide up to 78 weeks of pre-employment support. DES providers can claim six quarterly service fees with an additional two quarterly service fees (26 weeks) made available if the job seeker is found to be in need of extended assistance. Once the job seeker finds work they move into the Post Placement Support phase. This includes payments to providers for job placement, 13 week and 26 week pathway or full-outcomes. Once a program participant has reached the 26 week employment milestone there is the option of ongoing support. In the DMS service, flexible ongoing support is provided if needed with an Ongoing Support Assessment every 52 weeks. The DES-ESS services are similar in structure but have the option of flexible, moderate and high ongoing support.

DES limits job search assistance to two years but offers time-unlimited support for people at work.

anticipation of discrimination has been shown to deter two thirds of people with mental illness from applying for work

Assessment Process for JSA and DES

The level and type of support received by job seekers is based on results from the Job Seeker Classification Instrument (JSCI), an Employment Services Assessment (ESAt) and or Job Capacity Assessment (JCA). Previously JCA included assessments for both employment services referral and Disability Support Pension eligibility however since July 2011 this has been split between ESAt and JCA respectively (DEEWR 2013).

- The JSCI is used and conducted by Centrelink officers to stream relatively less disadvantaged job seekers. The assessment draws primarily on information disclosed by the job seeker, but can also make use of information gathered independently by Centrelink.
- The ESAt is used by health and allied health professionals to determine the type of employment services and assistance that are required by the most disadvantaged job seekers.
- The JCA is used by health and allied health professionals for the purposes of determining a person's medical eligibility for DSP. Unlike the ESA, the JCA is not primarily employment services driven.
- The Department of Human Services (DHS) Assessment Services is responsible for conducting ESAt and JCAs.
- Entry to Stream 4 JSA is based on an Employment Services Assessment or Job Capacity Assessment.

The JSCI tries to ascertain whether a job seeker has complex barriers to employment that require further assessment through an ESAt in an attempt to find the most suitable service. The ESAt determines whether the job seeker can be best served by DES-DMS, DES-ESS, JSA streams one through four or be recommended to other programs like sheltered employment at an Australian Disability Enterprise (Department of Employment 2013). The ESAt can also assess the job seeker as being unable to benefit from employment services (Ibid.).

These ESAt also dictate how many hours a job seeker is expected to be able to achieve (hour employment benchmark) which has flow on effects for providers claiming outcome payments. There are employment benchmark bandwidths of 0–7 hours, 8–14 hours, 15–22 hours, 23–29 hours and 30 or more hours (Ibid.).

The section of the JSCI related to Disability/Medical Conditions is aimed at finding the relative labour market disadvantage faced by job seekers. The assessment allocates points to a job seeker based on their responses to a JSCI questionnaire which is complemented by

information ascertained through the ESAt or JCA (for DSP recipients). The higher someone's score on the JSCI the further they are assessed as being from the labour market. This supplementary information allows for automatic updating of a job seeker's JSCI, their work capacity and hourly benchmark. If someone declined to answer the questions on the JSCI they are assigned a one point score (DEEWR 2012).

The Work Capacity component overrides the Disability/Medical Condition component when a job seeker is assessed as being able to work less than 30 hours per week. This means zero points are allocated to the job seeker for the Disability/Medical Condition component

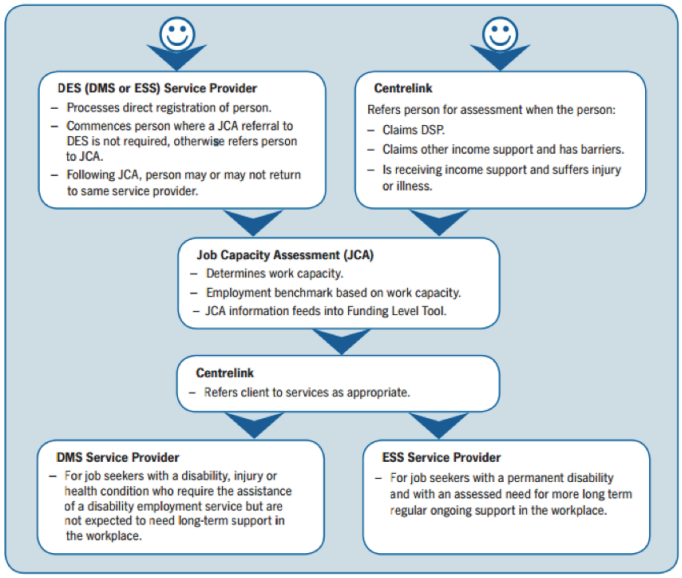

Figure 2: Pathways to DES (Reproduced from Evaluation of DES 2012 DEEWR)

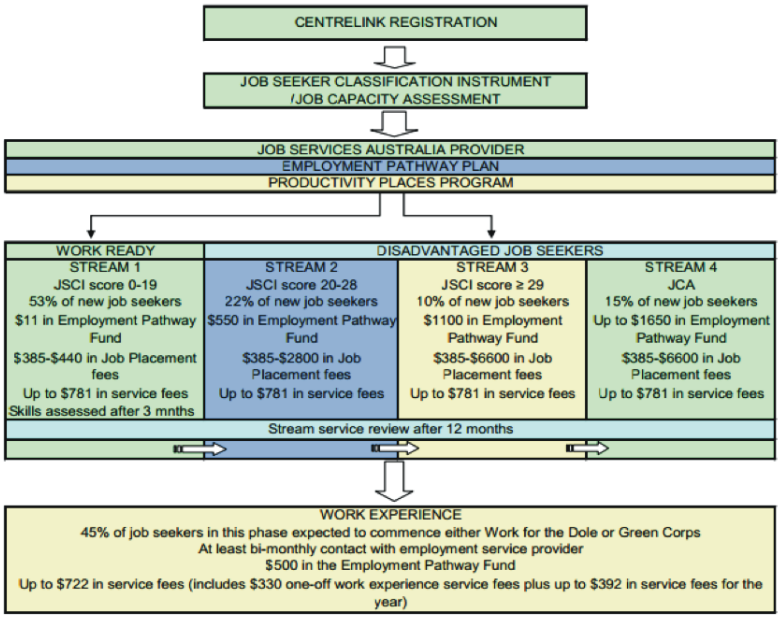

Figure 3: Reproduced from Evaluation Strategy for JSA DEEWR 2009

Funding Structures for JSA

JSA providers receive service fees, Employment Pathway Fund credits, funding for the work experience phase, payments for job placements as well as 13 and 26 week pathway and full-outcomes. These payments vary based on assessments of a job seeker's distance from the labour market or level of disadvantage as dictated by their stream of service.

For a complete description of all fees payable to JSA providers refer to the Deed.

Service fees	Stream one	Stream two	Stream three	Stream four
First 13 weeks	$63	$271	$332	$587
Second 13 weeks	$414	$208	$264	$512
Third 13 weeks	$94	$202	$257	$409
Fourth 13 weeks	$96	$204	$267	$411
Fifth 13 weeks	Na	Na	Na	$402
Sixth 13 weeks	Na	Na	Na	$415
Total	$667	$885	$1120	$2736

Work experience phase	Amount ($)
First 13 weeks	$456
Second 13 weeks	$66
Third 13 weeks	$133
Fourth 13 weeks	$67

Compulsory activity phase	Amount ($)
First 13 weeks	$133
Second 13 weeks	$66
Third 13 weeks	$133
Fourth 13 weeks	$67

Amount ($)	Stream one	Stream two	Stream three	Stream four
Employment pathway fund	$11	$550	$1100	$1100 +$550 after 12 months of unemployment in stream four
Early school leaver bonus to EPF	NA	$500	$500	$500

Outcomes	Stream one	Stream two	Stream three	Stream four
Job placement fee	$385-$440	$385-$550	$385-$550	$385-$550
Full outcome	$572-$854	$675-$1400	$1418-$3300	$1418-$3300
Full outcome +bonus	$686-$1025	$810-$1680	$1702-$3960	$1702-$3960
Pathway outcome	$252-$376	$446-$550	$446-$1100	$891-$1100
Pathway outcome +bonus	$302-$451	$535-$660	$535-$1320	$1069-$1320

Funding Structures for DES

DES providers receive service fees, job placement fees, outcome payments, ongoing support fees and job in jeopardy payments.

There are a variety of different outcome payments in DES: a Job in Jeopardy Outcome, a Pathway outcome and a Full Outcome. A DES provider can only claim one of either the Pathway Outcome or Full Outcome payments in a single service period.

There is also a 52 week indicator which is an outcome measurement not attached to any additional funding. This is linked to performance.

Full outcomes refer to a variety of circumstances but of particular relevance for this report it refers to people placed in jobs for 13 or 26 weeks at or above the hourly employment benchmark as assessed by Centrelink. Full outcomes also refer to people aged 15-21 years old without a Year 12 or equivalent qualification who complete a semester of a course that is at least one year long.

Pathway outcomes require a job seeker to work two-thirds of their assessed capacity. Pathway outcomes also refer to a person aged between 15 and 21 years who finishes a semester of a course that is at least one year long and meets the Qualifying Education Course requirements.

The provision of Job in Jeopardy assistance in the DES system is aimed to helping employees at risk of losing their job due to their disability or health condition. The DES provider can help the worker as soon as they present to the service working with the person and their employer to help the retention of employment. To receive a Job in Jeopardy Outcome someone must remain in employment for the normal amount of hours per week for 26 weeks after the date which they started receiving the assistance.

There are payments for ongoing support that depend on the level of intensity. Ongoing support can be provided in flexible, moderate and high settings.

There are also bonus payments for employment outcomes achieved that are related to training programs.

Providers can use money from the Employment Assistance Fund to help people experiencing problems as a result of their condition access specialist mental health services.

For a complete listing and description of fees paid to DES providers refer to the Deed.

Service fees	DMS	ESS Funding level 1	ESS Funding level 2
First 13 weeks	$1,595	$890	$1,900
Second 13 weeks	$1,595	$890	$1,900
Third to sixth 13 weeks Service fees	$715	$890	$1,900
Extended assistance first and second 13 weeks	$715	$890	$1,900
Total	$7,480	$7,120	$15,200
Outcome payments	**DMS**	**DES-ESS FL1**	**DES-ESS FL2**
Job placement	$770	$770	$1,540
13 week full outcome	$2,860	$2,860	$5,500
26 week full outcome	$4,400	$4,400	$7,700
13 week pathway	$945	$945	$1,815
26 week pathway	$1,450	$1,450	$2,540

Performance Evaluation and the Star Ratings system in DES and JSA

Contracts are tendered by the Department for JSA every three years and for DES every five years. Providers are referred clients based on their market share. This means a fixed share of business or referrals within Employment Services Area (ESA) is given to the employment service provider. The market share can be increased or decreased based on the provider's performance which is calculated using the Star Ratings system. A star rating of one, two or three means an employment service provider can have their business share reallocated to a higher performing service. The Department undertakes this review every 18 months and takes any extenuating circumstances into consideration during the reallocation.

Performance of service providers is assessed against a set of Key Performance Indicators around efficiency, effectiveness and quality. Efficiency is understood as the proportion of referrals to a provider that start in the employment services program and the time taken by providers to place job seekers in employment. The effectiveness KPI refers to the proportion of job seekers that achieve outcomes or in other words find work. The quality indicators are assessed against compliance with the Employment Services Deed and look at organisational health, types of services provided and client experiences.

The KPIs around efficiency and effectiveness inform the five-tier Star Ratings system. Each KPI is assessed through a number of separate performance measures which are combined using weightings chosen by the government into an overall assessment of performance. The Star Ratings system is then used to look at the relative performance of providers. Ratings are based on the percentage difference between each site's performance and the national performance average. Differences in labour market conditions and job seeker characteristics are taken into account using statistical regression. The system is designed to allow comparisons between providers.

Providers who receive a five-star rating are assessed as being 40% or more above the national average. Four-star providers are those who achieve performance 20% to less than 40% above the national average. Three-star providers achieve performance between 20% below the national average to less than 20% above the national average. Two-star providers are assessed as between 50% below and less than 20% below the national average. One-star providers are 50% or more below the national average.

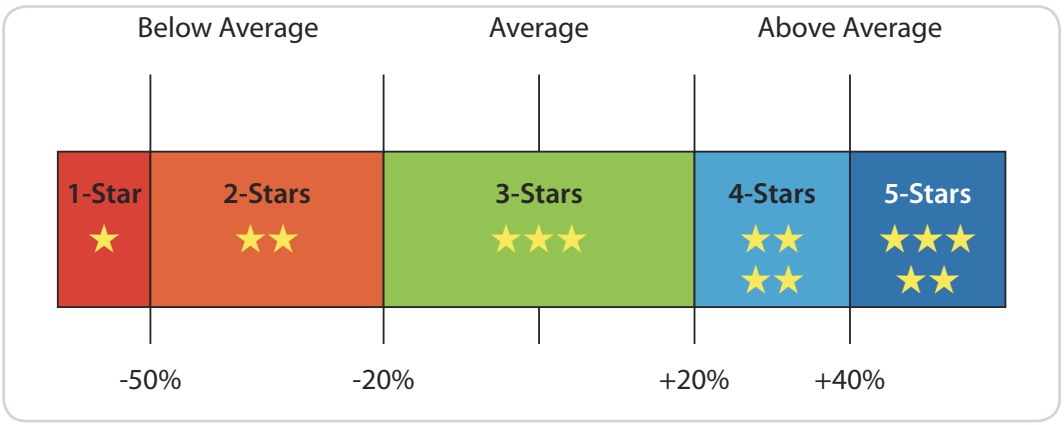

Figure 4: Distribution of star ratings (reproduced from DES star ratings methodology advice v1.1 Australian Government 2013)

Performance measures and Weightings for DES and JSA are different. The following tables will set out the measures and weightings for each of the programs.

JSA performance measures and weightings

Performance Measure	Weightings in JSA Star Ratings Model			
	Stream 4 40%	Stream 3 30%	Stream 2 20%	Stream 1 10%
13 Week Full Outcomes	20%	20%	20%	10%
13 Week Pathway Outcomes	10%	10%	10%	5%
13 Week Bonus Outcomes	15%	15%	15%	10%
Speed to 13 week Full Outcomes		5%	5%	
13 Week Outcomes Total	45%	50%	50%	25%
26 Week Full Outcomes	20%	30%	30%	10%
26 Week Pathway Outcomes	10%	10%	10%	5%
26 Week Outcomes Total	30%	40%	40%	15%
Barriers Serviced	15%			
Social Outcomes Total	15%			
Paid Placements	10%	10%	10%	30%
Speed to Job Placements				10%
Job Placements Total	10%	10%	10%	40%
Off Benefit				15%
Speed to Going Off Benefit				5%
Off Benefit Total				20%

Source: Job Services Australia Star Rating methodology From July 2012 to June 2015, Australian Government.

DES performance measures and weightings

	Performance Measure	DMS Weighting	ESS Weighting
2.1	Job Placements Proportion of participants who are placed into employment	5%	5%
2.2	13 Week Outcomes	35%	30%
2.2.1	13 Week Full Outcomes Proportion of participants who achieve a 13 Week Full Outcome	(25%)	(20%)
2.2.2	13 Week Pathway Outcomes Proportion of participants who achieve a 13 Week Pathway Outcome	(5%)	(5%)
2.2.3	13 Week Bonus Outcomes Proportion of relevant anchors that convert to a paid 13 Week Bonus Outcome or a 13 Week Full or Pathway Outcome for Indigenous participants	(5%)	(5%)
2.3	26 Week Outcomes	45%	40%
2.3.1	26 Week Full Outcomes Proportion of participants who achieve a 26 Week Full Outcome	(35%)	(30%)
2.3.2	26 Week Pathway Outcomes Proportion of participants who achieve a 26 Week Pathway Outcome	(5%)	(5%)
2.3.3	26 Week Bonus Outcomes Proportion of relevant anchors that convert to a paid 26 Week Bonus outcome or a 26 Week Full or Pathway Outcome for Indigenous participants	(5%)	(5%)
2.4	52 Week Sustainability Indicator/Job in Jeopardy Proportion of anchors for employment that convert into a 52 Week Sustainability Indicator and the proportion of JiJ anchors which convert to a JiJ outcome	10%	10%
2.5	Ongoing Support Proportion of ongoing support participants who remain in employment or exit ongoing support as an Independent Worker	5%	15%

Source: reproduced from DES star ratings methodology advice v1.1 Australian Government 2013

The Department of Employment is currently undertaking an evaluation of JSA. This will look at the current arrangements with a view to improving participation, effectiveness, efficiency and cost-effectiveness, and the evaluation will feed into the next tender for services in 2015.

DES providers have recently gone through a tendering process where one-, two- and three-star providers re-tendered for contracts. The next round of contract tendering will occur in 2018.

Employment policy implications and recommendations

This section sets out the performance of the various employment services for job seekers with mental illnesses. There are not separately reported outcomes for young people with mental illness. The report then describes areas that could be changed to effect improvements in the outcomes achieved by people with mental illness. This section not only sets out changes to the employment services but also the Disability Support Pension in order to encourage more people with mental illness back into the workforce.

Results in the Job Services Australia system

There are around 700,000 unemployed Australians at any given time. Almost a third are unemployed for more than two years (DEEWR 2012-13). The 2012-13 DEEWR annual report shows that 22.6% of stream four job seekers were employed after three months in the JSA system and a further 20.2% of job seekers in stream four were in an education or training program (Ibid.). Each employment outcome in stream four JSA represented a cost of $7,539 (Ibid.). However, despite the employment services system helping to place more than 1.6 million

people into jobs since 2009 (Ibid.) fewer than 20% of the most disadvantaged job seekers have found employment that has lasted 26 weeks through JSA (Jobs Australia 2013).

Data on the number of people with mental illness and the outcomes they achieve in the JSA system are not publicly reported which is problematic in analysing effects on this cohort, even more so when trying to specifically understand the situation facing young people with mental illness.

A 2010 report by the Mental illness Fellowship of Australia stated that "However the efficacy of Australian employment assistance services for people with mental illness remains largely unknown due to multiple disconnected programs and fragmented data collection. Currently in Australia evaluation of specialised employment assistance is ad hoc and it is difficult to identify the effective programs, or the effective elements of programs that can lead to improved service development." (Mental Illness Fellowship 2010 p8).

However, the latest report on JSA released in September 2013 does give us an idea of the effectiveness of the system for all people with disabilities. These are job seekers who either through their Job Seeker Classification Instrument (JSCI) or Employment Services Assessment (ESAt) were determined to have a disability or medical condition or who were in receipt of DSP when they commenced their phase of assistance.

In the year ending September 2013, 32.7% of job seekers with a disability gained employment (8.5% full-time and 24.2% part-time) three months following participation in JSA, compared with 42.8 per cent of all job seekers. Participation in education and training for job seekers with disability was also lower at 18.7 per cent compared to 22.7 per cent for all job seekers (Department of Employment 2013). The results for each stream in the year ending September 2013 three months following participation in JSA were as follows (Department of Employment 2013):

- 22.8% of stream 1 participants with a disability achieved full-time employment, 29.3% part-time, 18.9% education & training and 8.8% were no longer in the labour force.
- 9.9% of stream 2 participants with a disability achieved full-time employment, 28.3% part-time, 19.8% education and training and 19.2% were not in the labour force
- 5% of stream 3 participants with a disability achieved full-time employment, 28.2% part-time, 18.8% education & training and 19.2% were not in the labour force
- 6.3% of stream 4 participants were employed full-time, 17.4% part-time, 18.1% education & training and 34.6% were not in the labour force

The results for disabled job seekers are not surprising given they require more intense individual support from employment services and caseloads for JSA in 2012 were reported to average 114 per employment consultant (Davidson 2013).

Results in the Disability Employment System

DES has recorded 170,000 job placements since March 2010 (DEEWR 2012-13). The stated target population of DES is "people who receive Disability Support Pension (DSP) plus people with disability who are in receipt of Newstart Allowance or Youth Allowance" (DEEWR 2012 p19). DEEWR's evaluation report released in 2012 stated that approximately 8.8% of the target population were using services in December 2010 up from 7.7% a year earlier (Ibid.).

Limiting the target population to people in receipt of the DSP allows for an analysis of people using DES by disability type. Among DSP recipients, participation in the programs for people with psychiatric disability (3.5%) is lower than learning or intellectual disabilities (8-10%) but higher than physical disabilities (1.8%) (Ibid.).

Data on the number of people with mental illness and the outcomes they achieve in the JSA system are not publicly reported which is problematic in analysing effects on this cohort, even more so when trying to specifically understand the situation facing young people with mental illness.

The DES evaluation report released in March 2012 looking at outcomes from March to December 2010 shows that of the 4,001 people with a psychiatric disability enrolled in the DMS program only 26.6% (1,066) were placed in a job and only 14.2% (568) reached the 13 week outcome (Ibid.). The figures are even worse for the DES-ESS programs. For DES-ESS funding level one 2,831 people with a mental illness were enrolled of which 24.2% (686) found a job and 14.2% (402) reached the

The star ratings system also allows for the performance of all providers to decline, drifting toward lower outcomes, while maintaining relative performance and their star rating

13-week outcome. There were 1,333 people with a psychiatric disability enrolled in DES-ESS funding level two of which 18.8% (251) were placed in employment and 10.6% (141) were still there after 13 weeks (Ibid.).

This compares poorly to the overall performance of DES as reported in DEEWR's 2011-12 annual report. The report says that 40.8% of people in DES-DMS were employed three months after participating in the employment service and 36% of people in DES-ESS (DEEWR 2011-12).

While data on caseload levels for DES providers is not publicly available, anecdotal reports indicate average levels of around 40-50 job seekers per employment specialist. This could be hampering services given these job seekers require intensive individual support. Write, Marston and McDonald said in a 2011 paper that "the demand for service, expressed in terms of large caseloads, works against the possibility of establishing ongoing rapport and tailored, individualized service delivery for clients. In short, the competencies of traditional human service case management are not conducive to the output imperative demands of the system" (Write, Marston & McDonald 2011 p313). A report produced by the Department of Education, Employment and Workplace relations in 2007 found increasing client-to-staff ratios was linked to lower employment rates (DEEWR 2007).

In addition, current participation and unemployment rates for people with mental illness illustrate that despite recent changes to employment services in Australia and an increase in spending on mental health programs, the majority of people suffering from psychiatric disorders are being excluded from the employment market.

Recommendation

In order to better target interventions, data on outcomes by age and disability type should be made publicly available.

Star Ratings

The star rating system is used to assess relative performance of JSA and DES providers. It uses statistical regression to create homogeneous cohorts for comparison, taking into account variables such as disability type and labour market conditions. While this is a useful tool in comparing employment service providers against each other it means that understanding differences in outcomes for different cohorts or disability groups is hindered. It is not comparing like for like outcomes in terms of hard-to-place job seekers with mental illness in one service compared to the same cohort in another service. The approach is too opaque meaning there is not enough transparency to connect provider action with employment outcomes.

The relative nature of star ratings also creates competition between providers to be better than each other rather than competition to reach expected absolute standards. As Considine says in his 2003 report this means that "in an environment of secrecy and with only one purchaser to please, contractors lack incentives to communicate good practice to others, including to the contractor" (Considine 2003 p75).

The star ratings system also allows for the performance of all providers to decline, drifting toward lower outcomes, while maintaining relative performance and their star rating (Waghorn 2011). Interestingly according to a 2007 SACES report, 95.1% of the differences in 26 week outcomes are not explained by client or labour market characteristics (SACES 2007). This means that the statistical regression used in the star ratings system to take into account client and labour market characteristics only accounts for 4.9% of the variance in 26 week employment outcomes which is in line with international evidence that client characteristics are not predictive of outcomes (Waghorn 2011).

Recommendation

In order to remove perversities created by the current star rating system, the Government should:

- Introduce absolute benchmarks for different disability groups based on historical data with annual reviews.

Employment Services Funding Structure

The payment structure for DES contains perverse incentives to over inflate caseloads and park the most difficult to place job seekers. This disadvantage is of particular importance to people facing the most severe barriers to employment such as those suffering mental illness who require the most intense individual support. While improvements have been made and outcome payments exist in both systems, the level of service fees means service providers can be financially sustainable in terms of hard to place job seekers without finding them work.

In JSA the most a provider receives from the four service fees in stream one is $581, in stream two, $885, in stream three $1120 and in stream four $2736 (Department of Employment 2012).

However, the four service fees attached to each job seeker in DES-ESS Funding level two amount to $11,400 over 18 months without any need for the provider to find the job seeker any employment. The additional two service fees available under the extended employment assistance provision bring that total to $15,200 (DEEWR 2013). There is $14,740 available to DES providers for the same job seeker in terms of the job placement fee, 13 and 26 week outcome payments (Ibid.). A DES provider gets more money for keeping someone on the books for two years without finding them a job than for quickly achieving employment outcomes. A caseload of 50 ESS funding level two clients over two years generates more than $750,000 in service fees alone which represents more than five times the two year salary of one full-time employment consultant (Waghorn 2011). While outcome payments help to offset rational profit maximising, the current setup fails to address rational profit maximisation motivation provided to over-inflate caseloads and park the hardest to place job seekers.

The justification for service fees is twofold. Firstly, the payments provide an impetus for providers to stay in regular contact with job seekers and secondly, the funding allows for the provision of resources for clients. While these are important factors in the provision of employment services, paying providers to stay in contact with clients is like paying a shopkeeper for staying in touch with her customers. In a high quality employment service, this should be happening anyway. This creates a perverse incentive to increase caseloads to unsustainable levels and park the most disadvantaged job seekers because funding is available for up to two years per client even if outcomes are not achieved.

Recommendations

Remove perverse incentives to overinflate caseloads and park or set aside the most disadvantaged job seekers by:

- Abolishing service fees and moving funding to outcome payments.
- Including quality of service and regular contact requirements in performance evaluation.
- Allow employment service providers credits or a portion of their funding based on their expected levels of job placements, 13 week, 26 week and 52 week outcomes. Any difference in expected outcomes and the actual outcomes achieved could then be recouped at the end of the financial year.
- Provide service fee funding on the basis that it must be spent on the job seeker and not within the employment service.

In order to improve incentives to providing quality services:

- Attach an outcome payment to the 52 week outcome indicator. This would promote long term employment options and incentivise employment service providers to seek sustainable work options.
- Introduce 65 week outcome payment.
- Investigate possible contract requirements to limit active caseload size to 25 job seekers per employment specialist.

Full outcomes vs Pathway outcomes

One structural issue in DES is the fact that providers can only claim payment for one 13 and 26 week outcome (DEEWR 2013). This is important as the Pathway outcome aimed toward educational achievement pays a lower fee than the full-outcome. There is therefore a disincentive for a rational profit maximising actor to seek anything but a full-outcome. While employment in the competitive labour market is rightly the aim of employment services the effects on young job seekers with low educational attainment warrants closer examination. Low levels of educational attainment amongst people suffering mental illness are worrying and have long term career implications as illustrated earlier in this report. This is particularly important for young job seekers in the DES system.

Recommendation

- Allow employment service providers to claim both a pathway outcome and full-outcome for young job seekers suffering mental illness who have low levels of education. This could be done on a pro-rata basis. If the job seeker achieves an employment outcome after a pathway outcome then the difference in the fees could be paid to DES providers.

Ongoing support

The provision of ongoing support in DES is essential for job seekers who face significant difficulty maintaining employment. However, its inclusion in the performance evaluation creates a perverse incentive to not offer ongoing support to people who most need it. This occurs when a provider knows the client is at risk of losing their job and instead of intervening as strongly as possible there is an incentive in order to maximise the performance measure to exit the DES participant.

Instead of using the proportion of successful ongoing support clients in the performance evaluation the Department could move to a slightly different model. The number of successful ongoing support participants could be used as a bonus factor in performance evaluation. This would remove the perverse incentive that currently exists to remove job seekers at risk of losing their job and in need of ongoing support and replace it with an incentive to provide these riskier DES participants support when they need it most.

Recommendations

Two options for removing the disincentive to offer ongoing support to job seekers most in need:

- Eliminate the perverse incentive to remove job seekers at risk of losing their job and in need of ongoing support by using the number of successful ongoing support participants as a bonus factor in performance evaluation instead of the proportion of successful ongoing support outcomes.
- Remove ongoing support as a measure that affects star ratings and simply reward ongoing support outcomes with current funding arrangements.

Assessment processes and classification

The classification process is another area that has improved due to recent reforms but is still problematic. There appears to be a lack of attention devoted to the effects of mental illness in the assessment process. According to the 2012 DES evaluation report 81.3 per cent of newly referred job seekers with a recommendation for DES DMS commenced in DMS and 74.2 per cent with a recommendation for DES ESS commenced in ESS (DEEWR 2012). This compares favourably to the previous iterations of disability employment services VRS (74.9%) and DEN (58.4%) (Ibid.). However, the second National Survey of Psychosis found that among those looking for work only 30.5% of people with psychotic disorders were using DES. 32.1% of people with psychosis were receiving help from Job Services Australia (Waghorn et al 2012). This is worrying because a job seeker cannot receive assistance from both DES and JSA at the same time and does not choose the type of assistance they receive. This means that "the mandatory national job capacity assessment system may be misclassifying up to 30% of people with psychotic disorders, by underestimating their assistance needs" (Waghorn et al 2012, p782).

This would seem to reinforce a goal outlined in the DES 2012 evaluation report which stated participants would benefit from "increased use of specialist assessments where indicated, particularly for job seekers with suspected undiagnosed mental illness; this would require a review of existing policy and possible significant budget implications" (DEEWR 2012 p xviii). The same report also indicated improvements to the JCA are needed to better encapsulate the support needs required by job seekers (Ibid.).

One example that could be used to improve assessment of psychiatric conditions is the Personal and Social Performance (PSP) scale. This is a 100-point rating scale based on assessment of a person's function in four areas:

- Socially useful activities
- Personal and social relationships
- Self-care
- Disturbing and aggressive behaviours

Morosini et al developed the scale and found it to be a good, fast, valid measure of patient's personal and social functioning (Morisini et al 2000; Brissos et al 2011). Each question is rated on a six point severity scale with the interviewer assigning a global functioning score based on the interview in the four areas and any additional information gained. The system allows for tracking of functioning in the four domains over time and in various phases of the illness which is particularly useful due to the episodic nature of mental illness. It has been used in randomised controlled trials, validated in several countries in both acute and stabilised patients showing reliability and sensitivity to long term changes in illness severity (Brissos et al 2011).

Recommendations

- Introduce a scale such as the PSP for assessment of mental health conditions to better capture the needs of this cohort of job seekers.
- Streamline assessment procedures for people with mental illness already on the DSP. This category of people should be encouraged to access employment services through the DES system and should not be allocated a prescribed hourly benchmark or face lengthy delays caused by assessment procedures that cause a loss of motivation. Any amount of work should be seen as a positive outcome in their journey to recovery.

Administration leading to standardisation

The administrative burden under DES has not been improved by recent reforms. The majority of DES providers (79%) believe there is a higher administrative burden under the new system (DEEWR 2012). According to the National Employment Services Association (NESA), providers' frontline staff spend around half of their time on administration (NESA 2013).

The high administrative burden is often reported by employment service providers as problematic. Changes to program settings can lead to DES providers having to focus more on compliance to avoid breaches of contract. In the two years before 2012 there had been a total of eight different guidelines released including 12 policy changes and ten clarifications. This represents a fraction of the 41 other sets of guidelines for DES providers. This snapshot illustrates the administrative and compliance burden placed on service providers.

The performance framework and service provider contracts have caused service standardisation in an attempt to minimise risk. A study by Considine et al in 2011 based on changes observed in survey data from 1998 and 2008 illustrated that "between the two studies there was a marked increase in the level of routinisation and standardisation on the front line. This suggests that the sector did not achieve the enhanced levels of flexibility so often identified as a desirable outcome of reform" (Considine et al 2011). As employment services have matured DEEWR, until recently the purchaser of Australian employment services, required providers to enter into more detailed contracts "which had the dual effect of reducing flexibility and eroding diversity between agencies" (Ibid.). Efforts by the department to increase contract compliance and punish providers through the refunding of fees and the reallocation of business share engendered fear and produced a greater push from providers to reduce risk through forms of service standardisation (Ibid.).

> A DES provider gets more money for keeping someone on the books for two years without finding them a job than for quickly achieving employment outcomes

During the 2008 Australian Government review of employment services submissions from peak employment service bodies NESA and Jobs Australia raised objections to the prescriptive and innovation-stifling practices (Commonwealth of Australia 2008).

As Bredgaard and Larsen put it "the general impression is that, in spite of freedom to choose their own methods, providers hardly ever come up with innovative solutions. Rather than developing new methods and innovating services, the providers' primary focus is on survival, and they are not willing to take any risks unless the outcome is considered certain" (Bredgaard & Larsen 2008 p345).

In response to the problems raised by NESA and Jobs Australia the Australian Government stated employment services need flexibility and resources to help the most disadvantaged job seekers (Commonwealth of Australia 2008).

However, given the administrative burden has been reported by service providers to have increased since this review there is a logical probability that employment service providers will continue to try and mitigate risk and in doing so limit innovation. As Considine et al put it, "what neither quasi-markets nor tight regulations succeed in doing on their own was to promote innovative solutions for the most vulnerable" (Considine et al 2011). This is particularly important for groups of job seekers such as those suffering mental illness who are disadvantaged by the current setup.

Disability Support Pension

The Commonwealth has looked at the disincentives to employment for people on the Disability Support Pension (DSP) that included (DEWR 2004):

Anticipated difficulty re-establishing entitlement to DSP

- Lack of knowledge of DSP suspension arrangements
- Lack of knowledge of earnings credits and applicable income tests
- Lack of knowledge of assistance available to obtain employment

Introducing a system that provides a safety net once people have been proved eligible creates both an incentive to work because you can earn more money and gets rid of the disincentive that currently exists around returning to work regarding loss of access to benefits. While it is rarely the case that a person will be worse off when working on the DSP, widely held perceptions and fear create disincentives to even try and return to work.

It is clear people with mental illness can be easily discouraged from trying to return to work. Setting up a system that supports and encourages people back into the workforce could help overcome these barriers.

Recommendations

- Provide high quality IPS services based in mental health services for young people in an effort to prevent a perceived need to access DSP in the first place.
- Require people with mental illness under the age of 25 to return to Centrelink once every three months to determine whether Disability Employment Services could help. This should not affect DSP eligibility. Instead it involves checking to see how the episodic impairment is progressing and if vocational rehabilitation should be considered as an option.
- Once a person has been deemed eligible for the DSP they should be able to return quickly to payments if they have tried to return to work and their condition has deteriorated. This means that a person who tries to work when on the DSP succeeds in finding a job and has their payment reduced to zero can rely on a safety net if their disability or illness gets worse.
- Introduce independent benefits counselling. In order to counter perceptions that working while on the DSP will leave the person worse off more information must be provided.

Section 4: Evidence-based employment interventions

This section of the report will set out possible alternatives to current employment services. Firstly by describing some characteristics of best practice according to the OECD then describing each model and finally by looking at research around employment outcomes for each model. The paper will then set out recommendations to improve the quality of and access to employment services.

Best Practice in Employment Services According to the OECD

The OECD launched a review in 2006 looking into policies that promote Jobs for Youth in 16 countries including Australia. Completed in 2009, the review identified the following features of 'best practice' in public employment services to facilitate the transition from school to work and improve the career prospects of youth.

- Early intervention. Programs should begin as early as possible to avoid lock-in effects of long term unemployment.
- Job search assistance. The report found that the most cost effective programs for young people are job search assistance programs. Wage and employment subsidy programs were found to have positive short-term impacts but were less positive long-term in regards to employment prospects.
- Connecting training programs to local and national labour markets requires private sector and local community involvement in project design.
- Targeting programs. Making sure that teenagers are helped with educational attainment while young adults are given opportunities to boost their work history.
- Focus on school dropouts.
- Integration of services into a comprehensive package is essential to best practice.
- Tight job search requirements.

Social Firms

Social Firms are a type of business or enterprise that employ people who face disadvantage in the open labour market due to their disability. These companies produce goods and services in competitive markets to pursue their social mission (Svanberg et al 2010; Williams et al 2012). People who are not disabled can work in these businesses but the purpose of social firms is to provide paid work to people with a disability as well as other disadvantaged job seekers. Social firms empower disadvantaged individuals and promote the physical, social and mental health of their members (Svanberg et al 2010). Through integration in the wider community, an understanding environment of mental illness and the provision of meaningful activities, employees can overcome barriers and discrimination faced in mainstream work settings (Secker et al 2003).

A study of two social firms in Scotland found that the feeling of inclusion encouraged in the businesses was beneficial to people with mental illness (Svanberg et al 2010). Having somewhere to go and activities with a visible purpose was beneficial not only because it acted as a distraction from symptoms but also due to the valuable social and vocational skills gained (Ibid.). Recovery was also aided by interactions in accepting social groups, a sense of belonging and added purpose (Ibid.). Providing an environment in which participants were more than just their mental illness facilitated a shift in self-concept and helped develop a sense of a hopeful future where the attainment of life goals despite ongoing symptoms was achievable (Ibid.).

A study looking at a social firm in Australia had similar findings (Williams et al 2012). Workplace features such

as pay, workplace conditions, job security, achievable but challenging tasks and a flexible work environment were found to be strongly supportive for people with mental illness (Ibid.). The report found three guiding principles for the development of supportive social firms. The three principles are: the provision of permanent jobs with statutory minimum awards and conditions; designing jobs to be regular, flexible & promote feelings of competence; and a naturally supportive social environment (Ibid.).

A Norwegian study found that social firms increase employability and subsequent job retention offering a helping hand to people who have been excluded from the labour market for significant periods or face large barriers to employment (Lysaght et al 2012). While few social firms are able to operate without some subsidies or external financial support there is potential for a reduction in the burden on taxpayers because social firms can act as an alternative type of rehabilitation service (Ibid.). There are also arguments that social firms segregate disabled people from the local community however there is something to be said about the flexible and supportive work environments as an avenue for marginalised groups (Ibid.).

Research from the UK suggests social firms are stable forms of employment for people with mental illness, which was illustrated by an average job retention of two years (Gilbert et al 2013). The study found absences due to sickness in social firms were around 8 days a year per employee compared to the UK average of 4.5 days (Ibid.). The report also found employers generally had an understanding of workers' conditions and liaised with mental health services meaning they were able to provide better levels of support and allay fears of clinicians that work could be harmful to their patients recovery (Ibid.). Another benefit could be seen in the greater ability of social firms to overcome barriers such as stigma and pressures of working while coping with mental illness due to the embedded ethos (Ibid.).

In Australia Supported Employment services provide employment within a commercial enterprise. This encapsulates Australian Disability Enterprises, which are similar to social firms. They target people with a disability who are unlikely to be able to work in the open employment market. They help people with a disability to take part in paid employment, develop capabilities and promote socialisation through activity in community life (FAHCSIA 2008). The Australian Government Disability Services Census 2008 reported there were 413 supported employment services (Ibid.). There were 22,167 people using supported employment services in 2007-08 of which 11.7% (2,585) had a psychiatric disability (Ibid.). A further 806 people had a psychiatric condition in addition to their primary disability (Ibid.). People with a psychiatric disability had the lowest employment outcomes at 92.1% (Ibid.).

There are five phases for people enrolled in a supported employment service; worker, work experience, job seeker, independent worker and other. (Ibid.) A worker is someone who has accepted a contract in a supported employment service. Someone in the work experience phase is undertaking paid or unpaid work experience or a trial at a supported employment service. A job seeker is a person receiving assistance from a supported employment provider to prepare or help place them in work. An independent worker is person assisted by a supported employment service to get a job who the following year receives no further help from the employment service. Other refers to a person engaged in non-vocational activities in a supported employment service (Ibid.).

Clubhouse Model

There are over 300 clubhouses worldwide and eight in Australia (ICCD 2013). These centres provide services to people with severe mental illness and are based on the model developed by a group of ex-patients who started the first clubhouse called Fountain House in 1948. There are 36 accreditation standards guided by four principles:

- A right to a place to come
- A right to meaningful work
- A right to meaningful relationships
- A right to a place to return

Clubhouses rely on both government and philanthropic funding and are run as independent centres linked to Fountain House via tri annual accreditation fees (Raeburn et al 2013). They offer a broad range of rehabilitation activities such as case management, social advocacy, housing assistance, psycho educational and employment programs. These services are aimed at increasing confidence and empowering people through supportive relationships (Ibid.).

The model's pre-vocational program is called "the work ordered day" which places members alongside paid staff in an attempt to build skills through helping with reception and administration, meal preparation and building maintenance activities (Ibid.). Through working in this typical business day in a rehabilitative environment, members can build confidence and a sense of capability (McKay et al 2005).

Another vocational program is called the transitional employment program (TEP). These positions act as a stepping stone towards paid employment in the open labour market and are organised between clubhouses and local businesses (Raeburn et al 2013). These jobs are offered for a limited duration and are designed to be part-time (McKay et al 2005). Members also have the opportunity to undertake transitional employment positions without work experience (Ibid.).

The third vocational offering is called the supported employment program (SEP). Clubhouses offer ongoing assistance to find, get and keep jobs in the competitive employment market through both onsite and offsite supports upon the member's request (Raeburn et al 2013; McKay et al 2005). Members may have to go through an interview process because these jobs are not linked or "owned" by the clubhouses and unlike the TEP employers select the employee (McKay et al 2005).

People also have the opportunity to partake in independent employment (IE). These positions require members to go through a fully competitive interview process. IE is characterised by the lack of a relationship between clubhouses and employers and the absence of onsite supports (Ibid.).

Criticisms of the model revolve around two areas, namely a lack of consistent access to psychiatric treatment and institutional dependence (Raeburn et al 2013; Crowther et al 2001). This concern around the reliance of members on the Clubhouses revolves around the possibility of compromising members' ability to move toward paid employment. However, the provision of a safe environment, social networks and employment opportunities are valuable for people suffering mental illness (Raeburn et al 2013).

McKay et al conducted a study looking at employment outcomes across the TEP, SEP and IE in 17 clubhouses in Massachusetts between 1998 and 2001 (McKay et al 2005). The study found that 1,702 members were employed in 2,713 separate job placements over the three year period (Ibid.). This included 1,107 placements in transitional employment, 730 SE and 877 in IE. The mean time to job in this study was 6.4 months and mean hours worked were 13.87 hours/week for TE, 18,3 hours/week in SE and 21.1 hours/week in IE (Ibid.). Employed members average clubhouse affiliation was 6.45 years (Ibid.). However, the study failed to report movement across job types and impacts on employment outcomes of the various programs.

A further study examined 138 clubhouse members and their progression from transitional employment to competitive employment (Henry et al 2001). It found that average tenure in TE was unrelated to the severity of disability and 30.4% (42) of members obtained competitive employment in the one year following their work transitional employment program (Ibid.). The report also indicates a link between total hours employed in TE and an increased probability of obtaining competitive employment (Ibid.). The study also found that rapid placement into TE and a better prior work history are factors important to predicting competitive employment outcomes (Ibid.). While this study looked at data from the early 1990s, its findings are still pertinent.

Individual Placement Support

Individual Placement Support (IPS) is an evidence-based employment services model for people with mental illness developed in the US (Drake et al 2012). The model has eight core principles:

1. **Competitive employment.** This principle describes the main aim of IPS. Job seekers are helped to find employment in the open labour market. Employment specialists do not help in finding sheltered employment, unpaid internships or jobs set aside for people with mental illness so often associated with the stepwise approach which has dominated the vocational rehabilitation sphere. This is because these approaches have demonstrated to not be effective in leading to competitive employment in the short or long term (Drake et al 2012). There is also evidence that competitive employment can have positive effects in other areas of people's lives (Ibid.).
2. **Eligibility based on client choice.** No job seekers are excluded on the basis of job readiness, diagnoses, severity of disability, symptoms, substance abuse or legal system involvement (Ibid.). The basis of involvement in an IPS service is based on desire to

work in a competitive job. Providers encourage clients to consider work as a possibility and talk about work possibilities during intake, treatment planning and mental health assessments. Opportunities are also provided to share stories of returning to work with other job seekers and people with mental illness in treatment groups and newsletters. Research has shown that screening for who can work through standardised assessments and assumptions by clinicians about patients who will not benefit from work are largely ineffective (Ibid.).

3. **Integration of employment services and mental health services.** This means IPS providers and mental health treatment teams are not only collocated but are closely integrated and work collaboratively. Employment specialists attend treatment team meetings and share ideas and information to develop ways to improve client functioning and recoveries (Ibid.).This has been difficult in many current IPS settings but the evidence of the increased effectiveness of employment services that are integrated in clinical treatment teams is well documented (Ibid.).
4. **Attention to Client Preferences.** Job searches are based on individual client preferences rather than employment provider judgements (Ibid.). Job searches are base on what the client wants, their strengths and work experiences. Job seekers list their employment history and identify characteristics they liked about previous positions. Clients also decide on work settings, wages and hours. Employment specialists provide suggestions to expand options and discuss the advantages and disadvantages of disclosing their illness to the prospective employers. Job seekers also determine whether employment specialists will be in direct contact with employers and discuss the types of supports they require. This aids in job retention and is based in a significant amount of literature that illustrates a connection satisfaction, longevity and client choice (Ibid.).
5. **Personalised benefits counselling.** Employment specialists provide or help find accurate and understandable information about the effects work will have on the job seeker's welfare payments (Ibid.). While fear of losing benefits is a significant barrier for people with mental illness seeking employment, most people on benefits will actually be better off financially if they return to work. However, a lack of understanding of the effects of wages and hours worked on pensions and support payments creates common misconceptions and fear around returning to the labour market.
6. **Rapid job search.** IPS providers start looking for employment opportunities immediately and help job seekers find work as soon as possible rather than providing lengthy assessments, training and counselling (Ibid.). Employment specialists work with clients in the first session to develop an employment plan and career profile based on client preferences, past experiences, skills, strengths, career goals and education. Face to face contacts with employers begin within the first month of the program. This helps maintain motivation and consolidates the feeling that employment specialists are working hard to achieve what the job seeker wants. It also helps to reinforce the job seeker's self confidence as employment specialist demonstrates their belief the person has skills. This does not refer to rapid placement in employment but rather the process of looking for work. Finding and placing job seekers in the first available job will often lead to a poor job fit and decrease job retention.
7. **Systematic job development.** IPS providers must build employer networks and relationships through systematic contacts. This is more than calling businesses looking for openings. It refers to creating relationships with employers by understanding the business and human resources. Future contacts revolve around discussions of possible employees when good job matches arise. There is evidence that poor skills in this area are very detrimental to the effectiveness of any employment service. This is important as people suffering mental illnesses often get discouraged and give up on self-directed job searches (Ibid.).
8. **Time unlimited and individualised support.** This means that job seekers can continue to receive support for as long as they require. IPS providers continue ongoing supports long after employment is found. Frequent contacts between employment specialists and clients are important even once in work to help with any required training and difficulties faced in the new environment. Once a person has held a job for a year then the employment specialist can discuss transitioning the client to another team member and off employment services. The developers of IPS argue that within the psychiatric rehabilitation sphere there has long been an understanding that artificial deadlines created through funding arrangements are counterproductive to long term work sustainability (Ibid.).

Evaluating the quality of IPS services

There is a 25-point fidelity scale that measures the quality of IPS services and research has shown services that achieve high scores produce better competitive employment outcomes (Bond et al 2012). Each item on the scale is rated from one to five with response alternatives linked to measureable elements of practice. There are three areas examined; staffing, organisation and services. The staffing section asks questions about caseload size, role of employment specialist and the services they provide. The organisation section assesses the integration of the service, contacts with clinicians, number and structure of employment specialists, the role of employment supervisor, zero exclusion criteria, the focus on competitive employment and executive team support. The services section looks at benefits counselling, disclosing disability information to employers, ongoing vocational assessments, rapid job search, individualised job search, job development, job types, ongoing support, time spent in and out of the office providing service and contacts with job seekers. The total for each section is added together with services scoring exemplary fidelity (115-125), good fidelity (100-114), fair fidelity (74-99) or not supported employment (0-73).

A recent Australian study looked at four IPS sites in regional New South Wales and found job seekers in the evidence-based employment model had three and a half times the odds of achieving 13 weeks employment than the people using DES (Waghorn et al In Press). Over nine months 45 out of 95 people (47.5%) started working, which compared to the national benchmark of 24.5% over the same period (Ibid.).

Another Australian study looked at the effectiveness of IPS as compared to treatment as usual for 41 people with first-episode psychosis (Killackey et al 2008). The results are compelling as 13 of 20 people receiving IPS found work compared with two out of 21 in the treatment as usual (TAU) group who were referred to external employment agencies (Ibid.). A further four people in each group enrolled in education bringing the success rate for the vocational intervention group to 85% (Ibid.). The 13 people in the intervention group also worked more hours per week (mean 33.9) compared to the TAU (mean 22.5) (Ibid.).

According to another study that looked at an IPS service in New Zealand outcomes for people with psychiatric disabilities can be greatly improved. The research reported 47% of 135 people found employment and 21% achieved educational outcomes (Porretous & Waghorn 2009).

Randomised controlled trials across the world have compared IPS (place and train) against the best available alternative vocational models (train and place) and found fidelity to the model leads to much improved outcomes among people with a mental illness. Across the studies those with higher fidelity achieved average outcomes of 61% gaining competitive employment compared to an average of 23% in sites using a train and place model (Bond, Drake & Becker 2008). Jobs found through IPS lasted an average of 24 weeks and were obtained around 10 weeks before the control groups (Ibid.).

In fact successful implementations of this evidence-based employment service for people with mental illness has now been documented in the USA (Bond et al 2001), the UK and Europe (Burns et al 2007), Canada (Latimer et al 2006), Hong Kong (Tsang et al 2009), Australia (Waghorn et al 2007; Killackey et al 2008) and in New Zealand (Porteous & Waghorn 2009). The Individual Placement Support model for vocational services has even been recommended for implementation by the House of Representatives Standing Committee on Education and Employment (Commonwealth of Australia 2012).

Additionally, IPS has also been adapted to education (Killackey et al submitted). In this small Australian study 18 out of 19 young people with a mental illness successfully returned to education through an IPS program. While preliminary data, the strong suggestion of these results is that IPS may be a very potent intervention when directed exclusively at education for young people with mental illness.

Integrating publicly funded mental health services with employment services is a barrier to implementing the evidence-based IPS model. This is partially due to the governance of the separate services and partially due to organisational culture. Each State and Territory is

The Individual Placement Support model for vocational services has even been recommended for implementation by the House of Representatives Standing Committee on Education and Employment

A study from the USA suggested that due to reductions in welfare payments, increased taxes, and decreased use of public health services, the implementation of evidence based IPS supported employment for people with mental illness could be achieved at little or no cost to government

responsible for mental health services but employment services are run by private organisations contracted to the federal government. There can also be push back from clinical teams not used to working in collaboration with employment service providers. The importance of integration can be seen in a 2009 study which reported employment outcomes of 60.3% over five months for an integrated service and 40% for a non-integrated service (Porteous & Waghorn 2009). The Victorian government is trialling delivery of IPS in two locations.

A study looking at challenges to implementing evidence-based employment services in Australia raised several issues (Waghorn et al 2007). The major barriers can be classified into three areas: the integration of vocational staff into the mental health team, the risk of isolation from employment staff and client eligibility and access issues (Ibid.).

Issues with integration:

- The time taken to plan and set up integrated services can put pressure on employment services financial sustainability due to performance pressures.
- No specific training programs have been developed for integrated employment specialists or mental health teams.
- Cultural differences can lead to a lack of support from clinical teams who might not think their patients can benefit from work.
- Confidentiality and insurance requirements can restrict cooperation.
- Occupational health and safety issues arising from employment specialists working in mental health units.

Issues with isolation from employment staff:

- There is a risk employment specialists become too involved and focused on clinical needs rather than employment outcomes.
- Employment specialists becoming isolated from other employment staff reducing access to industry information and job opportunities.

Client eligibility and access:

- The current assessment procedures for job seekers accessing employment services can exclude clients based on factors such as not being able to benefit from 8 hours work to not being in receipt of benefit payments. This contradicts the evidence-based criterion of zero exclusion.
- Clinical staff filtering referrals and only sending job seekers who they characterise as job ready to employment service providers

Minor issues identified by the study were as follows:

- Limiting active caseloads to a maximum of 25 job seekers per employment specialist.
- Perceptions of inequity can grow from the different size of caseloads for integrated employment specialists and other employment specialists.
- Difficulties maintaining financial sustainability during initial phase due to small initial caseloads and a reliance on case-based funding outcome payments.
- Preserving a focus of vocational staff on employment services.
- Monitoring of work performance and attitudes to improve job retention.
- Avoiding delays in starting job search caused by capacity assessments and income support eligibility
- Ensuring follow-up support for job seekers isn't curtailed due to DES and JSA funding arrangements.
- Avoiding office-bound services.
- Proactively reaching out to clients to improve employment outcomes.
- Calculating the implications of returning to work on social security payments.
- Proving assistance with education.

The use of a regional trainer and Centre for Excellence could help overcome issues of implementation and ensure high fidelity. A State Trainer programme has produced successful results in 13 States in the US (Centre for Mental Health 2012). Using an online database would allow for the dissemination of knowledge and improve implementation issues. Regional trainers can help skill up employment services, bring about organisational change and conduct fidelity checks to ensure the program veracity. These experts can also assist in the development of action plans to overcome barriers. The provision of a centre for excellence would

also allow for support to be provided in setting up and improving services. There is already a significant group of IPS experts in Australia which would aid in the development of such a service.

A study from the USA suggested that due to reductions in welfare payments, increased taxes, and decreased use of public health services, the implementation of evidence based IPS supported employment for people with mental illness could be achieved at little or no cost to government (Drake et al 2010). Two reviews put the costs of IPS services per job seeker in the first year of service at US$4000 in 2006 dollars (Latimer et al 2004; Salkever 2010). A Canadian study suggested it could be funded across Quebec for half the cost of current ineffective services (Latimer et al 2011). A study across six European sites found that not only were results in IPS employment services better than treatment as usual but were also more cost effective (Knapp et al 2013). Given the large current investment in employment services in Australia it is likely IPS could be implemented without additional expenditure.

A New Zealand study found that integration was difficult but focussing on other key fidelity measures allowed the service to achieve good employment outcomes (Browne et al 2009). The study found that the design of funding contracts can support the implementation of evidence-based practices.

Recommendations

- Work toward a new contract framework for specialist employment services working with people with mental illness which better supports the implementation of the IPS model. Such a contract could set absolute standards for outcomes based on historical data while using the fidelity measures as a quality assurance performance evaluation framework.
- Through the COAG processes move to insert measurable performance requirements around integration of federally contracted employment service providers with State contracted mental health services.
- Further development of Social Firms and Clubhouses in order to offer a holistic approach to employment services for people with mental illness.
- Establish a national centre for excellence in evidence-based employment services to disseminate information on best practice, train employment specialists & work on improvement plans and undertake auditing of fidelity to the IPS model.

Section 5: A new approach

This section proposes a new way to approach education and employment interventions for young Australians with mental ill health. It takes advantage of work that has already been done evaluating IPS supported employment in young people with severe mental illness. It also uses an existing service structure for delivery.

As detailed in this report, the traditional approaches to employment have failed for people with mental illness. As a consequence as a group they are more unemployed and greater recipients of DSP than any other disability group. A new approach is needed.

Government policy through the National Mental Health plans has been for mental health services to have a recovery focus. At the same time, the importance of early intervention has been recognised through the establishment in 2006 of headspace. There are currently more than 60 headspace centres around Australia providing primary mental health care for young people aged 12-25. In addition headspace will soon be launching 9 specialist early psychosis services. Marrying the early intervention focus of headspace to the evidence based effectiveness of IPS employment services would lead to significant gain for young people with mental illness in terms of educational and employment outcomes.

headspace

headspace is a nationally funded mental health organisation providing care to young people with mild to moderate conditions (headspace 2011). Since its inception in 2006, headspace has helped more than 100,000 young people (headspace 2012/13).

The federal Department of Health provides funding to the headspace National Office. Consortia bid to establish headspace centres in local areas. The successful centres are then provided with funding from headspace national office. Clinical services are provided primarily through medicare funding. Employment is one of the four pillars of headspace. In most situations, this is achieved through inclusion of an employment agency in the bidding consortia, or through referral to local employment agencies.

Two problems are apparent in the current orientation of headspace vocational services. One is that many people going to headspace who could benefit from government funded vocational services are not eligible because they are not yet on a benefit and their illness has not yet developed to the stage where they would be incapacitated enough to qualify to access DES. This means a person has to wait until they are eligible for employment benefits before they can gain the assistance of employment services even if they face the significant barriers to the labour market presented by mental health conditions.

> the traditional approaches to employment have failed for people with mental illness ... A new approach is needed

The second problem is that the provision of employment services is not necessarily co-located with the rest of the headspace services. It may be in the same building, but it could be in another building completely. The benefits of co-location are thus not achieved.

The advent of the early psychosis clinics in some headspace sites offers an intriguing glimpse of what might be possible. The new early psychosis services have to provide 16 elements in their services for young people. One of these is that they need to employ an IPS worker to provide educational and employment recovery services to young people (Stavely et al., 2013). Exporting this model to the wider headspace centres would be a great leap forward in both the provision of true recovery oriented services, as well as holistic early intervention.

This could be done through the reallocation of some money from the employment services to headspace for the employment of dedicated IPS workers in headspace centres. Alternatively, existing employment agencies could continue their partnership with local headspaces by agreeing to provide high-fidelity IPS services. This would require a change in practice for many agencies, but would lead to better outcomes in terms of employment and education for young people with mental illness.

Recommendations

- Introduce federally funded IPS employment and education services as part of the headspace model that do not require assessment or social security benefit eligibility to improve both education attainment in younger people and transitioning to the workforce for the slightly older cohort.
- Improve the implementation of evidence-based employment services by establishing an accreditation system for providers based on high fidelity to evidence-based practices.

Section 6: Recommendations

This report has reviewed the landscape facing young people with mental illness who wish to pursue educational and employment goals. Our strong recommendation is that a refocusing of strategy to the delivery of IPS employment and educational services should be provided through the headspace platform. This is likely to be the best method of achieving the government's policy aims by providing a viable and evidence based method for people to avoid commencement on the DSP. For those on a DSP, IPS is a bridge back to education, training and employment. To that end the following key recommendations are made. Other recommendations arising from our review of this area then follow.

- Fund high fidelity IPS employment and education services to be provided to young people presenting to headspace centres around Australia. These services would be fully embedded and come under the governance of headspace. This could be funded from a range of current funding sources.
- Use the headspace national dataset to capture the data about an integrated model and use this to evaluate and refine the provision of these services.
- Using lessons from the scaling up and implementation of IPS at headspace centres, expand IPS services into mainstream community mental health services for all mental health consumers who wish to work or return to study.
- Develop anti-stigma campaigns targeting employers, families, young people and primary care providers to break down attitudes that imply that young people with mental illness cannot or should not work.
- Educate mental health clinicians about the importance of employment and education as a part of, not the product of, recovery. Such a program to be led by the National Centre of Excellence in Youth Mental Health.
- Through the provision of comprehensive early intervention services that address both symptomatic and functional needs, provide a viable pathway to return to employment and education.

Recommendation: Treatment rates.

- Create a new Medicare benefit class for people under the age of 25 receiving treatment that either:
    - requires bulk billing; or
    - provides psychologists and psychiatrists with a slightly higher payment in exchange for getting rid of co-payments.

Recommendation: Education

- Develop a nationally consistent approach to funding and supporting programs aimed at engagement (and re-engagement) and wellbeing to address inadequate funding and reduce differences between jurisdictions in policy and practice.
- Improve staff to student ratios in important programs such as Student Support Services Officers through increased funding attached to disadvantaged students and schools.
- Improve funding structures for alternative education settings that deal with students who are receiving clinical treatment.

- Develop supported education policies in mainstream settings for students before they are referred to mental health services with funding structures that allow for growth.
- Continue to work with schools, students and parents to promote mental health literacy and enhance resilience and support teachers to recognise issues and refer students with mental illness to someone better placed to treat the condition.

Recommendation: Employment Services Star Ratings

In order to remove perversities created by current Star Ratings system, the Government should:

- Introduce absolute benchmarks for different disability groups based on historical data

Recommendation: Employment Services Funding Structure

Remove perverse incentives to overinflate caseloads and park or set aside the most disadvantaged job seekers by:

- Abolishing service fees and moving funding to outcome payments.
- Including quality of service and regular contact requirements in performance evaluation.
- Allow employment service providers credits or a portion of their funding based on their expected levels of job placements, 13 week, 26 week and 52 week outcomes. Any difference in expected outcomes and the actual outcomes achieved could then be recouped at the end of the financial year.

Option two:

- Reduce levels of service fees and introduce requirement that funding must be spent on the job seeker and not within the employment service.

In order to improve incentives to providing quality services:

- Attach an outcome payment to the 52-week outcome indicator. This would promote long-term employment options and incentivise employment service providers to seek sustainable work options.
- Introduce 65-week outcome payment.
- Investigate possible contract requirements to limit active caseload size to 25 job seekers per employment specialist.

Recommendation: Full outcomes vs Pathway outcomes

- Allow employment service providers to claim both a pathway outcome and full-outcome for young job seekers suffering mental illness who have low levels of education. This could be done on a pro-rata basis. If the job seeker achieves an employment outcome after a pathway outcome then the difference in the fees could be paid to DES providers.

Recommendation: Ongoing support

Two options for removing the disincentive to offer ongoing support to jobseekers most in need:

- Eliminate the perverse incentive to remove job seekers at risk of losing their job and in need of ongoing support by using the number of successful ongoing support participants as a bonus factor in performance evaluation instead of the proportion of successful ongoing support outcomes.
- Remove ongoing support as a measure that affects star ratings and simply reward ongoing support outcomes with current funding arrangements.

Recommendation: Assessment processes and classification

- Introduce a scale such as the PSP for assessment of mental health conditions to better capture the needs of this cohort of job seekers.
- Streamline employment services assessment procedures for people with mental illness already on the DSP. This category of people should be encouraged to access employment services through the DES system and should not be allocated a prescribed hourly benchmark or face lengthy delays caused by assessment procedures. Any amount of work should be seen as a positive outcome in their journey to recovery.

Recommendation: Disability Support Pension

- Require people with mental illness under the age of 25 to return to Centrelink once every three months to determine whether Disability Employment Services could help. This should not affect DSP eligibility. Instead it involves checking to see how the episodic impairment is progressing and if vocational rehabilitation should be considered as an option.
- Once a person has been deemed eligible for the DSP they should be able to return quickly to payments if they have tried to return to work and their condition has deteriorated. This means that a person who tries to work when on the DSP succeeds in finding a job and has their payment reduced to zero can rely on a safety net if their disability or illness gets worse.
- Introduce independent benefits counselling. In order to counter perceptions that working while on the DSP will leave the person worse off more information must be provided.

Recommendation: Evidence-based employment services

- Work toward a new contract framework for specialist employment services working with people with mental illness, which better supports the implementation of the IPS model. Such a contract could set absolute standards for outcomes based on historical data while using the fidelity measures as a quality assurance performance evaluation framework.
- Through the COAG processes move to insert measurable performance requirements around integration of federally contracted employment service providers with State contracted mental health services.
- Further development of Social Firms and Clubhouses in order to offer a holistic approach to employment services for people with mental illness.
- Establish a national centre for excellence in evidence-based employment services to disseminate information on best practice, train employment specialists & work on improvement plans and undertake auditing of fidelity to the IPS model.

Recommendation: headspace

- Introduce federally funded IPS employment services as part of the headspace model that do not require assessment or social security benefit eligibility. This would help improve both educational attainment in younger people and their transition to the workforce.
- Improve the implementation of evidence-based employment services by establishing an accreditation system for providers based on high fidelity to evidence-based practices.

Section 7: Conclusion

This report has examined a number of the barriers to the participation in employment and education of young Australians with mental illness. Several recommendations have been identified which if implemented will lead to greater participation of this group in the workforce. This is an inherent, social and economic good. The Australian Government must implement evidence-based employment services for people with mental illness as a matter of both social and economic urgency. There has been significant recent discussion about the DSP and reforms associated with it. People with mental illness are the biggest group on the DSP and yet survey after survey finds that as a group they want to work. They do not want to be dependent on benefits. What has been missing in the discussion is the method by which a bridge is created from the DSP to sustainable employment. Even less discussed is how to assist people to not need to get onto the DSP in the first place through supporting them to complete education and transition successfully into the workforce. Individual Placement and Support fits this brief when applied early in the course of illness. Its high employment success rate and easy adaptation to educational support make it deserving of policy support and practice implementation.

Too often young people with a mental illness who wish to further their education or seek employment are told that they are dreaming if they think it is possible to do those things with a mental illness. Despite prevailing stereotypes, stigma and well-meaning but misdirected carers and clinicians, young people with mental illness continue to hold tight to their dreams of a future that involves a meaningful role and social and economic participation. They hold these dreams despite the barriers that stand in their way. Increasingly, evidence shows that there are ways for young people with mental illness to reconnect with their vocational dreams. It is incumbent on all stakeholders to identify practices and policies that currently prevent this and work to remedy those policies and practices that can be remedied. Where remedy is not possible it is imperative to develop new policies and practices. This report makes a contribution to this process.

References

ABC (2013) Labor Party ad overreaches on Coalition school funding cuts. Available at: http://www.abc.net.au/news/2013-09-02/alp-ad-overreaches-on-coalition-school-funding-cuts/4925242. Accessed on: April 7 2014.

(ABS) Australian Bureau of Statistics (2012) Australian Social Trends. Disability and Work 1993-2009. Available at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features40March+Quarter+2012#SPOT. Accessed on: April 7 2014.

(ABS) Australian Bureau of Statistics (2011) Australian Social Trends. Year 12 attainment. Available at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features40Mar+2011. Accessed on: April 7 2014.

(ABS) Australian Bureau of Statistics (2009) Disability and Mental Health. Perspectives on Education and Training: Social Inclusion 2009. Canberra.ABS (2007) National Survey of Mental Health and wellbeing. Available at: http://www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0. Accessed on: April 7 2014.

(ABS) Australian Bureau of Statistics (2005) Disability, Ageing and Carers, Australia: Disability and Long Term Health Conditions. Table 17: Persons aged 15-64 Disability Groups by labour force status and industry sector. Canberra.

AIHW (2013) Australia's welfare 2013. Available at: http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129544075. Accessed on: April 7 2014.

Alvarez-Jimenez, M., Gleeson, J. F., Henry, L. P., Harrigan, S. M., Harris, M. G., Killackey, E., . . . McGorry, P. D. (2012). Road to full recovery: longitudinal relationship between symptomatic remission and psychosocial recovery in first-episode psychosis over 7.5 years. Psychological medicine, 42(3), 595-606. doi: 10.1017/S0033291711001504

Bond, Drake, Becker (2012) Evidence for the Effectiveness of Individual Placement and Support Model of Supported Employment. http://sites.dartmouth.edu/ips/files/2013/01/Evidence-IPS_11_2013.pdf

Bond, Drake, Becker (2012) Generalizability of the Individual Placement Support (IPS) model of supported employment outside the US. World Psychiatry 11.p 32-39.

Bond, Drake, Becker (2008) An update on randomized controlled trials of evidence-based supported employment. Psychiatric rehabilitation journal 31(4)p280-290.

Bond G, Becker D, Drake R et al (2001) Implementing supported employment as an evidence-based practice. Psychiatric Services 52(3). P 313-322.

Bond G, Peterson A, Becker D, Drake R (2012) Validation of the Revised Individual Placement and Support Fidelity Scale. Available at: http://ps.psychiatryonline.org/data/Journals/PSS/24697/pss6308_0758.pdf. Accessed on: April 7 2014.

Bredgaard T and Larson F (2008) Quasi-markets in employment policy: do they deliver on promises? Social Policy and Society 7. P 341-352.

Browne D, Stephenson A, Wright J, Waghorn G (2009) Developing high performing employment services for people with mental illness. International Journal of Therapy and Rehabilitation Vol 16 No. 9. P502-511.

Browne D, Waghorn G (2010) Early Inervention the real world: employment services as an early intervention for young people with mental illness. Early intervention in psychiatry 4. P327-335.

Brissos S, Molodynski A, Dias V, Figueira M (2011) The importance of measuring psychosocial functioning in schizophrenia. Annals of general psychiatry. Available at: http://www.annals-general-psychiatry.com/content/pdf/1744-859X-10-18.pdf. Accessed on: April 7 2014.

Burns T, Catty J, Becker T (2007) The effectiveness of supported employment for people with severe mental illness: A randomised controlled trial. Lancet 370(9593). P1146-1152.

Carr V, Waghorn G (2013) To love and to work: The next major mental health reform goals. Australian & New Zealand Journal of Psychiatry 47(8). P 696-698.

Centre for Mental Health (2012) Briefing 44: Implementing what works: the impact of the individual placement and support regional trainer. Available at: http://www.centreformentalhealth.org.uk/pdfs/briefing_44.pdf. Accessed on: April 7 2014.

Commonwealth of Australia (2014) National Disability Insurance Scheme. Supports the NDIS will fund in relation to education. Available at: http://www.ndis.gov.au/sites/default/files/documents/fact_sheet_supports_ndis_fund_education.pdf. Accessed on: April 7 2014.

Commonwealth of Australia (2013-14) Top 20 programs by expenses 2013-14. Table 3.1. http://www.budget.gov.au/2013-14/content/bp1/html/bp1_bst6-01.htm

Commonwealth of Australia (2012-13) Budget 2012-13 Education, Employment and Workplace Relations. Available at: http://www.budget.gov.au/2012-13/content/ministerial_statements/rural_and_regional/html/rural_and_regional-08.htm. Accessed on: April 7 2014.

Commonwealth of Australia (2012) Work Wanted: mental health and workforce participation. House of Representatives standing committee on Education and Employment. Australian Government. Canberra.

Commonwealth of Australia (2011) National Disability Strategy 2010-2020. Canberra: Commonwealth of Australia.

Commonwealth of Australia (2009) Fourth National Mental Health Plan – An agenda for collaborative government action in mental health 2009-14. Canberra. Australian Government.

Commonwealth of Australia (2008) The Future of Employment Services in Australia Discussion Paper. Available at: http://www.ames.net.au/files/file/Policy/15_DEEWR_DiscussionPaper_May_08.pdf. Accessed on: 7 April 2014

Considine M, Lewis J, O'Sullivan S (2011) Quasi-Markets and Service Delivery Flexibility Following a Decade of Employment Assistance Reform in Australia. Cambridge University Press.

Considine (2003) Governance and Competition: The Role of Non-profit Organisations in the Delivery of Public Services. Australian Journal of Political Science.

Crowther R, Marshall M, Bond G, Huxley P (2001) Helping people with sever mental illness to obtain work: systematic review. BMJ 322. P204-208.

Cunningham M, Orsmond D, Price F (2014) Employment outcomes of the economically disadvantaged. Report for the reserve bank of Australia. Available at: http://www.rba.gov.au/publications/bulletin/2014/mar/pdf/bu-0314-3.pdf. Accessed on: April 7 2014.

Davidson P (2013) Is Job Services Australia made to measure for disadvantaged jobseekers? Centre for Public Policy, Employment Services for the Future Conference, University of Melbourne. Available at: http://public-policy.unimelb.edu.au/sites/default/files/public/davidson-employment%20services%20conference13.pdf. Accessed on: April 7 2014.

Department of Education (2013) More Support for Students with a disability. Available at: http://education.gov.au/more-support-students-disabilities. Accessed on: April 7 2014.

Department of Education (2011) Youth Connections program guidelines. Available at: http://docs.education.gov.au/system/files/doc/other/youth_connections_program_guidelines_september_2011_0.pdf. Accessed on: April 7 2014.

Department of Education, Employment and Workplace Relations (2013) Disability Employment Services Deed. Canberra. Australian Government.

DEEWR (2012-13) Disability Employment Services budget papers 2012-13. Available at: http://www.budget.gov.au/2012-13/content/ministerial_statements/rural_and_regional/html/rural_and_regional-08.htm. Accessed on: April 7 2014.

DEEWR (2012-13) DEEWR Annual Report 2012-13. Available at: http://docs.education.gov.au/system/files/doc/other/deewr_annual_report_2012-13.pdf. Accessed on: April 7 2014.

DEEWR (2012) Evaluation of Disability Employment Services Interim Report Reissue March 2012. Canberra. Australian Government.

DEEWR (2012) Employment Services – building on success, Issues Paper. Available at: http://docs.employment.gov.au/system/files/doc/other/2015_issues_paper_-_final_0.pdf. Accessed on: April 7 2014.

DEEWR (2012) Job Seeker Classification Instrument – Factors and points. Available at: http://docs.employment.gov.au/system/files/doc/other/job_seeker_classification_instrumentfactors_and_points.pdf. Accessed on: April 7 2014.

DEEWR (2009) Evaluation Strategy for Job Services Australia 2009-2012. Available at: http://docs.employment.gov.au/system/files/doc/other/evaluation_strategy_for_job_services_australia_2009_to_2012.pdf. Accessed on: April 7 2014.

DEEWR (2008) Employer attitudes to employing people with mental illness. Canberra: Australian Government. Available at: http://docs.employment.gov.au/system/files/doc/other/employer_attitudes_to_employing_people_with_mental_illness.pdf. Accessed on: April 7 2014.

DEEWR (2007) Disability Employment Network Case-based Funding Model. Evaluation Report. Final Report. Canberra: Australian Government.

Department of Employment (2013) Components and results of the JSCI. Available at: http://employment.gov.au/components-and-results-job-seeker-classification-instrument#questions. Accessed on: April 7 2014.

Department of Employment (2013) Labour Market Assistance Outcomes: Job Services Australia. Available at: http://docs.employment.gov.au/system/files/doc/other/labour_market_assistance_outcomes_report_september_2013_-_job_services_australia.pdf. Accessed on: April 7 2014.

Department of Employment (2012) Employment Services Deed 2012-15 – draft deed. Available at: http://docs.employment.gov.au/system/files/doc/other/request_for_tender_for_job_services_australia_20122015_draft_deed.pdf. Accessed on: April 7 2014.

Department of Employment (2012) Job Services Australia star ratings methodology from July 2012 to June 2015. Available at: http://docs.employment.gov.au/system/files/doc/other/jsa-star-ratings-methodology-july-2012-to-june-2015-fact-sheet.pdf

Department of Employment and Workplace Relations (DEWR) (2004) Job Network Disability Support Pension Pilot: Interim evaluation report. Employment Analysis and Evaluation Group, Evaluation and Programme Performance Branch. Canberra. Australian Government.

(FAHCSIA) Department of Families, Housing, Community Services and Indigenous Affairs (2012) Targeted Community Care (Mental Health) program guidelines. Available at: http://www.dss.gov.au/sites/default/files/documents/11_2012/targeted_comm_care_prog_guidelines_parta.pdf. Accessed on: April 7 2014.

FAHCSIA (2008) Australian Government Disability Services Census 2008. Available at: http://www.dss.gov.au/sites/default/files/documents/05_2012/disability_services_census-2008.pdf. Accessed on: April 7 2014.

Department of Health and Aging (2007) Utilisation of Mental Health and Medicare Items. Canberra. Australian Government. http://www.health.gov.au/internet/main/publishing.nsf/Content/2282AE98B9A287A8CA257BF0002046D0/$File/utitab.pdf.

Department of Human Services (2014) Skills for Education and Employment: eligibility criteria. Available at: http://www.humanservices.gov.au/customer/services/centrelink/skills-for-education-and-employment. Accessed on: April 7 2014.

Department of Human Services (2013) Disability Support Pension. Available at: http://www.humanservices.gov.au/customer/services/centrelink/disability-support-pension. Accessed on: April 7 2014

Department of Industry (2013) History, features and objectives of skills for education and employment program. Available at: http://www.innovation.gov.au/skills/LiteracyAndNumeracy/SEE/Pages/Overview.aspx. Accessed on: April 7 2014.

Department of Industry (2013) Program guidelines: Skills for Education and Employment Program . Available at: http://www.innovation.gov.au/Skills/LiteracyAndNumeracy/SEE/Documents/ProgramGuidelines.pdf. Accessed on: April 7 2014.

Department of Industry (2013) Australian Apprenticeships Advisors program. Available at: http://www.australianapprenticeships.gov.au/program/australian-apprenticeships-advisers-program. Accessed on: April 7 2014.

Department of Industry (2013) About Australian Apprenticeships. Available at: http://www.australianapprenticeships.gov.au/about-australian-apprenticeships. Accessed on: April 7 2014.

Department of Industry (2013) Support for Australian Apprentices with a Disability. Available at: http://www.australianapprenticeships.gov.au/sites/default/files/publication-documents/SupportForAADisability_0.pdf. Accessed on: April 7 2014.

Department of Industry (2013) Australian Apprenticeships Access Program. Available at http://www.australianapprenticeships.gov.au/programs/access-program. Accessed on: April 7 2014.

Department of Social Services (2013) Characteristics of the Disability Support Pension. Canberra. Australian Government. http://www.dss.gov.au/sites/default/files/documents/01_2014/dsp_characteristics_report_2013_final.pdf

Department of Social Services (2013) DES Star ratings and methodology advice v1.1. Available at: https://docs.employment.gov.au/system/files/doc/other/disability_employment_services_star_ratings_methodology_advice.docx. Accessed on: April 7 2014.

Drake R, Bond G, Becker D (2012) Individual placement and support: and evidence-based approach to supported employment. New York. Oxford University Press.

Drake R, Skinner J, Bond G (2010) Social Security and mental illness: reducing disability with supported employment. Health Affairs 28. P 761-770.

Drake R, Becker D, Bond G (2003) Recent research on vocational rehabilitation for persons with severe mental illness

Gilbert E, Marawaha S, Milton A, Johnson S, Morant N, Parsons N, Fisher A, Singh S, Cunliffe D (2013) Social firms as a means of vocational recovery for people with mental illness: a UK survey. BMC Health Services research 13:270.

Headspace (2012-13) Headspace annual report. Available at: http://www.headspace.org.au/media/712967/annual%20report%202013.pdf Accessed on: April 7 2014.

Headspace (2011) Headspace is helping thousands of people get their lives back on track. Available at: http://www.headspace.org.au/media/75806/prospectus_web.pdf. Accessed on: April 7 2014.

Henry A, Bareira P, Banks S, Brown J, McKay C (2001) A Retrospective Study of Clubhouse-based Transitional Employment. Psychiatric Rehabilitation Journal Vol 24(4). P 344-354.

Ho, B.-C., Andreasen, N., & Flaum, M. (1997). Dependence on public financial support early in the course of schizophrenia. Psychiatric Services, 48(7), 948-950.

ICCD (2013) Clubhouse International directory. Available at: http://www.iccd.org/search_form.php. Accessed on: April 7 2014.

Iyer, S. N., Mangala, R., Anitha, J., Thara, R., & Malla, A. K. (2011). An examination of patient-identified goals for treatment in a first-episode programme in Chennai, India. Early intervention in psychiatry, 5(4), 360-365.

Jobs Australia (2013) Reforming employment assistance: A blueprint for the future. Published by Jobs Australia Limited.

Killackey, E., Allott, K., Woodhead, G., Connor, S., Dragon, S. & Ring, J. (Submitted). Individual Placement and Support Supported Education in Early Stage Mental Illness: An Exploratory Study.

Killackey E (2014) Welfare to work: a different approach for people with mental illness. Available at: https://theconversation.com/welfare-to-work-a-different-approach-for-people-with-mental-illness-22293. Accessed on: April 7 2014.

Killackey E, Jackson H McGorry P (2008) Vocational intervention in first-epsiode psychosis: individual placement and support v. Treatment as usual. The British Journal of Psychiatry 193. P114-120.

Killackey E, Waghorn G (2008) The challenge of integrating employment services with public mental health services in Australia: Progress at the first demonstration site. Psychiatric Rehabilitation Journal 32(1). P 63-66.

Knapp M, Patel A, Curran C, Latimer E, Catty J, Becker T, Drake R, Fioritti A, Kilian R, Lauber C, Rossler W, Tomov T, Busschbach J, Comas-Herrera A, White S, Wiersma D, Burns T (2013) Supported employment: cost-effectiveness across six European sites. World Psychiatry 12 p60-68

Latimer E, Bond G, Drake R (2011) Economic approaches to improving access to evidence-based and recovery-orientated services for people with severe mental illness. Canadian Journal of Psychiatry 56. P523-529.

Latimer E, Lecomte T, Becker D (2006) Generalisability of he individual placement and support model of supported employment: results of a Canadian randomised controlled trial. British Journal of Psychiatry 189. P65-73.

Latimer E, Bush P, Becker D, Drake R, Bond G (2004) How much does supported employment for the severely mentally ill cost? An exploratory survey of high-fidelity programs. Psychiatric Services 55. P 401-406.

Lysaght R, Jakobsen K, Granhaug B (2012) Social Firms: A means for building employment skills and community integration. Work 41 (4). P 455-463

Marawaha S, Johnson S, Bebbington P, Angemeyer M, Brugha T, Azorin J, Killan R, Komfield A, Mondher T (2008) Correlates of subjective quality of life in people with schizophrenia: findgins from a European study. Journal Nerv Ment Dis 196(2). P87-94.

McGorry P, Goldstone S (2011)Is this normal? Assessing mental health in young people. Australian Family Physician Vol 40 No.3. p94-97.

McKay C, Johnsen M, Stein R (2005) Employment Outcomes in Massaschusetts Clubhouses. Psychiatric Rehabilitation Journal Vol 29(1). P25-33.

McKee-Ryan F, Song Z, Wanberg C, Kinicki (2005) Psychological and physical well-being during unemployment: a meta-analytic study. Journal of Applied Psychology 90.

Mental Illness Fellowship of Victoria (2013) Submission to the DEEWR on Improving the employment participation of people with disability in Australia. Available at: http://mifellowship.org/sites/default/files/Improving_employmentparticipation_Feb2013.pdf. Accessed on:7 April 2014.

Mental Illness Fellowship (2010) Mental illness and employment: challenges for the future. Available at: http://www.mifa.org.au/sites/www.mifa.org.au/files/4.%20MIFA%20ATMI%20Employment%20Final%20060810.pdf. Accessed on: April 7 2014.

Morisini P, Magliano L, Brambilla L, Ugolini S, Pioli R (2000) Development, reliability and acceptability of a new version of the DSM-IV Social and Occupational Functioning Assessment Scale (SOFAS) to assess routine social functioning. Acta Psychiatrica Scandinavica Vol 101(4). P 323-329.

Neil A, Carr V, Mihalopoulos, Mackinnon A, Morgan V (2014) Costs of psychosis in 2010: Findings from the second Australian National Survey of Psychosis. Australian and New Zealand Journal of Psychiatry 48(2). P 169-182.

Neil A, Carr V, Mihalopoulos C, Mackinnon A, Lewin T, Morgan V (2014) What a difference a decade? The costs of psychosis in Australia in 2000 and 2010: Comparative results from the first and second Australian nationa surveys of psychosis. Australian and New Zealand Journal of psychiatry 48(3). P 237-248.

NESA (2013) Red tape reductions to disability employment services welcome. Available at: http://medianet.com.au/releases/release-details?id=792181. Accessed on: April 7 2014.

Porteous N, Waghorn G (2009) Developing evidence-based supported employment services for young adults receiving public mental health services. New Zealand Journal of Occupational Therapy 56(1). P34-39.

Porteous N, Waghorn G (2007) Implementing evidenced-based employment services in New Zealand for young adults with psychosis: progress during the first five years. British Journal of Occupational Therapy 56(1). P34-39.

Raeburn T, Halcomb E, Walter G, Cleary M (2013) An overview of the clubhouse model of psychiatric rehabilitation. Australian Pschiatry 21 (4). P376-378.

Ramsay, C. E., Broussard, B., Goulding, S. M., Cristofaro, S., Hall, D., Kaslow, N. J., . . . Compton, M. T. (2011). Life and treatment goals of individuals hospitalized for first-episode nonaffective psychosis. Psychiatry research, 189(3), 344-348. doi: 10.1016/j.psychres.2011.05.039

Rinaldi, M., Killackey, E., Smith, J., Shepherd, G., Singh, S. P., & Craig, T. (2010). First episode psychosis and employment: a review. International review of psychiatry, 22(2), 148-162. doi: 10.3109/09540261003661825

Rutman I (1994) How psychiatric disability expresses itself as a barrier to employment. Psychosocial Rehabilitation Journal. Vol 17(3). P 15-35.

Salkever D (2010) Toward a social cost-effectiveness analysis of programs to expand supported employment services: An interpretive review of the literature. Available at: http://aspe.hhs.gov/daltcp/reports/2010/supempLR.pdf . Accessed on: April 7 2014.

South Australian Centre for Economic Studies (2007) Independent statistical review of the Disability Employment Netowkr (DEN) star rating model. Final report. Canberra: Department of Employment, Education and Workplace Relations.

Stavely, H., Hughes, F., Pennell, K., McGorry, PD., & Purcell, R. (2013) EPPIC Model and Service Implementation Guide. Orygen Youth Health Research Centre; Melbourne.

Submission 62 (2011) Submission 62 to the house standing committee on education and employment inquiry into mental health and workforce participation. Available at: file:///C:/Users/Sergio/Downloads/http---www.aphref.aph.gov.au-house-committee-ee-mentalhealth-subs-sub62.pdf. Accessed on: April 7 2014.

Svanberg J, Gumley A, Wilson A (2010) How do social firms contribute to recovery from mental illness? A qualitative study. Clinical Psychology and Psychotherapy 17. P482-496.

Secker J, Dass S, Growve B (2003) Developing social firms in the UK: a contribution to identifying good practice. Disability and Society 18(5). P659-674.

Thornicroft G, Brohan E, Rose D, Sartorius N, Leese M, (2009) Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. The Lancet 373(9661) p408-415.
Tsang H, Chan A, Wong A, Liberman R (2009) Vocational outcomes of an integrated supported employment program for individuals with persistent and severe mental illness. Journal of Behavior Therapy Experimental Psychiatry 40(2): 292-305

URBIS (2011) Literature review on meeting the psychological and emotional wellbeing needs of children and young people: models of effective practices in educational settings. Prepared for the NSW Department of Education and Communities. Available at: https://www.det.nsw.edu.au/media/downloads/about-us/statistics-and-research/public-reviews-and-enquiries/school-counselling-services-review/models-of-effective-practice.pdf. Accessed on: April7 2014.

Victorian Auditor General (2012) Student Completion Rates. Available at: http://www.audit.vic.gov.au/publications/20121128-Students/20121128-Students.pdf. Accessed on: April 7 2014.

Victorian Auditor General (2012) Programs for students with special needs. Available at: http://www.audit.vic.gov.au/publications/2012-13/20120829-Special-Learning-Need/20120829-Special-Learning-Need.pdf. Accessed on: April 7 2014.

Waghorn et al (In Press) implementation of evidence-based supported employment in regional Australia. Intended for the Psychiatric Rehabilitation Journal.

Waghorn G, Sukanta S, Harvey C, Morgan V, Waterreus A, Bush R, Castle D, Galletly C, Stain H, Neil A, McGorry P, McGrath J (2012) 'Earning and learning' in those with psychotic disorders: The second Australian national survey of psychosis. Australian & New Zealand JJournal of Psychiatry 46(8). P774-785.

Waghorn G (2011) Presentation to the Australian Government's Parliamentary Inquiry into Mental Health and Workforce Participation. Submission 15.1. Available at: http://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=ee/mentalhealth/subs/sub15.1.pdf. Accessed on: April 7 2014.

Waghorn G (2011) Standing Committee on Education and Employment- Mental health and workforce participation. Available at: http://parlinfo.aph.gov.au/parlInfo/search/display/display.

w3p;adv=yes;orderBy=customrank;page=0;query=workwise;rec=14;resCount=Default. Accessed on: April 7 2014

Waghorn G, Collister L, Killackey E, Sherring J (2007) Challenges to implementing evidenced-based supported employment in Australia. Journal of Vocational Rehabilitation 27. P29-37

Waghorn G, Lloyd C (2005) The employment of people with mental illness. Available at: http://www.mifa.org.au/sites/www.mifa.org.au/files/MIFA%20Employment.pdf. Accessed on: April 7 2014.

Waghorn G, Chant D, White P, Whiteford H (2004) Delineating disability, labour force participation and employment restrictions among persons with psychosis.Acta Psychiatric Scand. 109(4). P279-288.

Waterhouse P, Kimberley H, Jonas P, Glover J (2010) What would it take? Employer perspectives on employing people with a disability. Report prepared for DEEWR. Available at: http://www.ncver.edu.au/wps/wcm/connect/e33baf2a-c4ce-4480-83af-472d572e4446/2219.pdf?MOD=AJPERES&CACHEID=e33baf2a-c4ce-4480-83af-472d572e4446. Accessed on: April 7 2014.

Whiteford H, Buckingham W, Harris M, Burgess P, Perkis J, Barendregt J, Hall W (2014) Estimating treatment rates for mental disorders in Australia. Australian Health Review 38. P80-85

Williams A, Fossey E, Harvey C (2012) Social firms: Sustainable employment for people with mental illness. Work 43. P53-62.

Write S, Marston G, McDonald C (2011) The Role of non-profit organisations in the mixed economy of welfare-to-work in the UK and Australia. Social Policy and Administration 45(3). P.299-318.

Psychiatric Rehabilitation Journal

Evidence-Based Supported Employment for People With Psychiatric Disabilities in Australia: Progress in the Past 15 Years

Geoffrey Waghorn, Eoin Killackey, Philleen Dickson, Liza Brock, and Catherine Skate

Online First Publication, June 17, 2019. http://dx.doi.org/10.1037/prj0000370

American Psychological Association

Psychiatric Rehabilitation Journal

1095-158X/19/$12.00

http://dx.doi.org/10.1037/prj0000370

Evidence-Based Supported Employment for People With Psychiatric Disabilities in Australia: Progress in the Past 15 Years

Geoffrey Waghorn
The ORS Group, Gosford, New South Wales, Australia, and The University of Queensland

Eoin Killackey
Orygen, The National Centre of Excellence in Youth Mental Health, Parkville, Melbourne, Australia, and The University of Melbourne

Phillen Dickson
Western Australian Association for Mental Health, Perth, Western Australia, Australia

Liza Brock
STEPS Group Australia, Caloundra, Queensland, Australia

Catherine Skate
Sydney, New South Wales, Australia

Objective: This report summarizes the major developments in Australia since the first introduction of Individual Placement and Support (IPS) in 2005 in order to outline the current situation and discuss future challenges and opportunities. ***Method:*** Using an informal snowball sampling method, all those known to be involved in IPS implementations in Australia in the last 5 years were contacted. ***Results:*** The program has expanded from 2 full-time employment specialists in 2005 to 87.6 in 2018. The expansion has been most promising in youth mental health where an initial national 14-site trial of IPS was recently expanded to 24 sites. If the trial is successful, IPS may become a core component of a national youth mental health initiative. Expansion in the adult community mental health sector has been constrained by several factors including the low priority for rehabilitation in the public mental health system. On the positive side, the availability of independent technical support from Western Australia means that all new IPS sites can receive expert technical support for program implementation, continuing high-fidelity delivery, external fidelity assessment, outcome evaluation, and cohort-based outcome reporting. ***Conclusion and Implications for Practice:*** The expansion of IPS in the public funded adult mental health sector has not kept pace with progress in the youth mental health sector. There is an urgent need for adult mental health services to cease excluding vocational rehabilitation from treatment, care, and recovery plans. Disability Employment Service contract managers could increase disincentives for providers to adopt high caseloads and low intensity services, at the expense of more intensive evidence-based practices.

Impact and Implications

The impact of Individual Placement and Support in Australia continues to gain momentum. However, progress in the adult mental health sector has lagged behind that in the youth mental health sector. This situation can improve by adult mental health services taking more responsibility for vocational rehabilitation as part of individual recovery plans. In addition, the national disability employment service network could increase the proportion of outcome-based funding to incentivize the adoption of evidence-based practices.

Keywords: Individual Placement and Support, Australia, psychiatric disabilities, mental illness

Geoffrey Waghorn, The ORS Group, Gosford, New South Wales, Australia, and The School of Clinical Medicine, The University of Queensland; Eoin Killackey, Orygen, The National Centre of Excellence in Youth Mental Health, Parkville, Melbourne, Australia, and Centre for Youth Mental Health, The University of Melbourne; Phillen Dickson, Western Australian Association for Mental Health, Perth, Western Australia, Australia; Liza Brock, STEPS Group Australia, Caloundra, Queensland, Australia; Catherine Skate, Independent Practice, Sydney, New South Wales, Australia.

This report presents original findings about the current state of Individual Placement and Support implementations in Australia. There are no conflicts of interest to declare.

Ethical approval for this study not required because no sensitive information is included, and permission was obtained for any information that identifies individuals or organizations.

Correspondence concerning this article should be addressed to Geoffrey Waghorn, The ORS Group, 12 McGinn Close, Dayboro, Queensland 4521, Australia. E-mail: geoff.waghorn@orsgroup.com.au

Evidence-based support for competitive employment designed specifically for people with psychiatric disabilities has become increasingly available throughout Australia since 2005. The Individual Placement and Support (IPS) approach is currently recognized as the most evidence-based approach to providing employment assistance for people with psychiatric disabilities (Bond, Drake, & Becker, 2012; Kinoshita et al., 2013; Lockett, Waghorn, Kidd, & Chant, 2017; Marshall et al., 2014). Since the first feasibility trial of the IPS program in Victoria in 2005 (Killackey & Waghorn, 2008; Waghorn, Collister, Killackey, & Sherring, 2007) in adult mental health services, the availability of this approach has expanded to seven mainland states and territories. These are Victoria, Queensland, New South Wales, Western Australia, South Australia, Tasmania, and the Northern Territory. Only the mainland Australian Capital Territory (population 397,397 in 2016) and other offshore island territories have yet to access this approach. The program has grown from involving two full-time employment specialists in Victoria (One at Shepparton and the other at Orygen Youth Health in Parkville, Melbourne) in 2005, to 87.6 full time equivalent employment specialists by July 2018. This national expansion occurred through several different pathways with each being supported by research and advocacy.

A Brief History of Mental Health and Employment Services in Australia

Australia has national systems for the delivery of mental health treatment and care, disability support services, and disability employment services. The national disability employment sector provides individual employment services for adults with disabilities. New disability employment services were first funded in 1986 with the passing of federal legislation to address the mainstream employment goals of adults with disabilities. This Act (Australian Government's Disability Services Act, 1986) sought to replicate the work of Professor Wehman at Virginia Commonwealth University in the United States, who developed the individualized "place then train" approach to competitive employment for people with intellectual and physical disabilities. This new approach provided an alternative to "train then place," which often involved long periods of general work preparation in sheltered workshops, group training centers, and psychiatric day programs (Brooke, Wehman, Inge, & Parent, 1995).

This national network of contracted service providers is now known as the Disability Employment Services (DES) network (Department of Social Services, 2014). The program now permits access by people with primarily substance use problems and addictions. The most recent contract for this program began in July 2018 engaging 134 nongovernment organizations delivering services from 4,000 sites. The previous contract (2010 through 2018) delivered DES to 768,000 individual jobseekers, approximately one quarter to one third of whom had a primary disability classified as psychiatric (Broadhead & Galke, 2018). Both the previous contract and the current DES contract are uncapped meaning that all eligible Australians can now obtain a fully funded place in this employment service program.

Although DES is a promising national service delivery network its overall success for people with more severe forms of mental illness and psychiatric disabilities has been disappointing compared with the more encouraging findings from Australian IPS trials. For instance, the DES evaluation of 2010 through 2013 (Department of Social Services, 2014; $N = 132{,}900$) showed that among participants with more severe psychiatric disabilities (employment support services funding level 2) only 31.2% commenced employment within 18 months. Furthermore, only 14.2% of those who began receiving employment assistance retained employment for 26 weeks or more within 18 months of first receiving employment assistance. In contrast Australian IPS implementations targeting the more severe level of psychiatric disabilities have achieved employment commencement rates of 42.5% (Waghorn, Dias, Gladman, Harris, & Saha, 2014) and 57% (Morris, Waghorn, Robson, Moore, & Edwards, 2014). In this trial of IPS in four locations in NSW, 32% of IPS participants retained employment for 26 weeks or more within 12 months of commencing employment assistance. More than twice the number of IPS participants attained this 26-week milestone 6 months earlier than those represented in the national DES evaluation. The aim of this report is to describe and summarize current IPS activity in Australia and identify the major developments since 2005 in order to assess the current situation and discuss future challenges and opportunities.

Method

Information for this report was gathered from individuals known to be involved in the implementation of high-fidelity evidence-based supported employment throughout Australia in the last 5 years. Using a snowball sampling method, information was also gathered about other locations where evidence-based employment services may have been implemented. Information provided was then aggregated for further classification and descriptive analysis. Names of organizations and individuals were not reported if permission to be named in this report was not obtained. Emails were sent to individuals known to be currently or previously involved. They were asked to provide relevant summary information that was readily available if non sensitive and not confidential. Respondents were asked to forward our request to others who may also be able to contribute.

No confidential information or information likely to identify specific organizations or individuals without their permission was sought. Formal ethics approval for this report was not considered necessary because the information sought was neither sensitive nor confidential and most was already in the public domain. The key information sources for this report are shown in Table 1. Because of the informal nature of this snowball method it is possible that the extent of IPS implementations in Australia is underestimated. However, no sites known to be attempting IPS declined to be included in this report. In addition, we did not attempt to measure the wider influence that IPS implementations may be having on the practices of other non-IPS DES providers.

Results

The information gathered showed that evidence-based practices in supported employment for people with psychiatric disabilities in Australia have expanded since early demonstration sites were established in 2005 (see Table 1). Although some previously implemented locations have ceased operating, even more new implementation sites have been established. IPS sites in the head-

Table 1
Current IPS Implementations in Australia

Source of information	State	Type of implementation	Number of FTE employment specialists	Fidelity reviews	Outcome evaluation	Comments
Western Australian Association of Mental health (WAAMH)	WA	DES-CMHS partnerships	8.5	Yes	Yes	Offers technical support to new and established IPS locations on a fee for service basis
WAAMH	WA	Headspace, direct employment	1.0	Yes	Yes	Technical support by WAAMH
Queensland Health, North Brisbane (Metro North)	QLD	DES-CMHS partnership	8.0	Yes	Planned	Partnerships with DES providers have been established at most mental health locations linked to Royal Brisbane and Women's Hospital, Prince Charles Hospital, Redcliffe, and Caboolture Hospitals
Queensland Health, South Brisbane (Metro South)	QLD	DES-CMHS partnership	5.0	No	Planned	Partnerships have been established at Woodridge, Logan Central, Browns Plains, Princess Alexandra Hospital, and Cleveland
Queensland Health Gold Coast	QLD	DES-CMHS partnership	2.0	No	Unknown	Located at Southport Community Mental Health
Steps IPS Program	QLD	DES-CMHS partnership	8.0	Yes	Yes	Partnerships have been established with mental health teams on the Sunshine Coast, Maryborough, Bundaberg, and Townsville
NSW Health	NSW	DES-CMHS partnership	13.5	Unknown	Unknown	These sites were previously supported under the VETE program; the main locations are Nepean Blue Mountains (4 FTE), South East Sydney (2), and Hunter New England local Health Districts (7.5)
SA Health	SA	DES-CMHS partnership	4.0	Yes	Planned	Coordinated by Country Health South Australia; technical support by WAAMH
SA Health	SA	DES-CMHS partnership	2.0	Not yet	No	Western Community Health in urban Adelaide
VIC Health	VIC	DES-CMHS partnership	2.0	Unknown	Unknown	St Vincent's Hospital (1) and Eastern Health (1)
Orygen Youth Health	VIC	Direct employment	3.6	Yes	Yes	Two RCTs of IPS in youth mental health have been completed—A third trial of IPS for young people with borderline personality disorder is about to commence
WAAMH	NSW	Headspace, direct employment	7.0	Yes	Yes	DSS sponsored trial sites of IPS in 14 Headspace locations
WAAMH	SA	Headspace, direct employment	5.0	Yes	Yes	
WAAMH	QLD	Headspace, direct employment	6.0	Yes	Yes	
WAAMH	VIC	Headspace, direct employment	4.0	Yes	Yes	
WAAMH	WA	Headspace, direct employment	4.0	Yes	Yes	
WAAMH	NT	Headspace, direct employment	2.0	Yes	Yes	
WAAMH	TAS	Headspace, direct employment	2.0	Yes	Yes	

Note. IPS = Individual Placement and Support; FTE = full-time equivalent; WAAMH = Western Australian association for mental health; DES-CMHS = disability employment service – community mental health service; VETE = vocational education training and employment, a discontinued New South Wales government program; NSW = New South Wales; SA = South Australia; VIC = Victoria; RCT = randomized controlled trial; DSS = Australian government department of social services; QLD = Queensland; WA = western Australia; NT = Northern Territory; TAS = Tasmania. 2. By July 2018, 87.6 full-time equivalent employment specialists were known to be delivering evidence-based Individual Placement and Support (IPS) employment services in Australia.

space sector represent 31 full-time employment specialists. Orygen Youth Health directly employs another 3.6 employment specialists. The remaining 53 employment specialists are operating in DES–Community Mental Health partnerships. Evaluation prospects for these initiatives are promising with fidelity reviews being conducted at sites representing 72.8% of all IPS employment specialists. Outcome evaluation is also being planned or conducted for sites representing 77.7% of these IPS employment specialists. IPS services in Australia have emerged via three distinct pathways. The origins of each pathway are described in the following text.

Establishing IPS Within the DES Program

The Australian DES program continues to provide opportunities to establish high-fidelity and high-performing IPS services. No special concessions are made for IPS within DES, despite the fact that IPS programs target clients with the most severe psychiatric disabilities. DES providers are not required by their contracts to adopt a particular model of vocational rehabilitation. The most salient difference between a non-IPS DES provider and these IPS sites is the lack of a partnership or formal collaboration with community mental health services. Another common difference is caseload size and program intensity. Although some DES providers have capped their caseloads to preserve program intensity, most do not and have varying caseloads, and many often have over 40 clients per employment specialist (Waghorn & Hielscher, 2015).

Potential IPS clients are typically involved with public mental health services and may lack the knowledge and confidence to find, select and access usual DES services. Therefore, to facilitate access to DES, this IPS pathway assists a DES service to form a partnership with a community mental health team in order to integrate mental health treatment and care with vocational support for competitive employment. It is rare for state government-delivered public adult mental health services to directly employ an employment specialist in Australia. This is because employment services for people with health conditions and disabilities are a federal government responsibility. Partnerships avoid the potential for service duplication. Although partnerships can be challenging to establish and require effective leadership to maintain, several examples over the last 15 years have shown that they are both feasible and sustainable (Morris et al., 2014; Parletta & Waghorn, 2016; Waghorn et al., 2012).

A large multisite trial of this pathway was funded by the Queensland Government in 2008. The results of this trial showed that the IPS intervention which involved a formal partnership between an adult mental health service and a DES provider, was more effective than local DES providers acting alone (Waghorn et al., 2014). In addition, implementation reports (Killackey & Waghorn, 2008; Morris et al., 2014; Parletta & Waghorn, 2016), policy analyses (Orygen Youth Health Research Centre, 2011, 2014), and commentaries (King, Waghorn, Lloyd, McLeod, McMah, & Leong, 2006; Waghorn & Hielscher, 2015) have discussed the ongoing challenges for implementing evidence-based practices in the Australian service delivery context.

Despite these challenges, several regions have persisted with this approach, and, in some locations, it has become a stable and established form of routine service provision. For example, in Brisbane, both Metro North and Metro South Hospital and Health Service Districts support multisite locations of DES employment specialists into community mental health teams. These partnerships are also established in New South Wales, SA, WA, and Victoria (see Table 1). However, most partnership based IPS implementations do not collect and report on cohort-based employment outcomes. Although the reasons remain unclear, the failure to implement a suitable evaluation plan could jeopardize the future of these partnerships.

IPS on the Sunshine Coast and in North Queensland

A well designed evaluation plan has been implemented by STEPS as part of an expanding IPS project on the Sunshine Coast. STEPS is a DES provider that has established partnerships with several mental health teams from the Sunshine Coast to Townsville, a regional city in North Queensland. The IPS program is led by Liza Brock (nee Scriven). STEPS has developed specialist IPS roles that partner with mental health teams. STEPS regularly assess program fidelity and records employment outcomes at an individual level at each location. A dedicated IPS Management position not only provides management and technical support to each partnership, but also collects accurate performance information on every referral to the program, while tracking every participant so that cohort-based employment outcomes can be reported on a rolling 12-month basis.

The STEPS IPS program performed well from 2010 through 2016, typically with 50% or more of all participants who commenced the program obtaining competitive employment. The total IPS caseload in 2016 was 160 participants. However, the program began to decline rapidly in 2017 because of several factors including a change in leadership arrangements for both STEPS and the mental health services. The designated STEPS IPS Program Manager position was dropped and Site Managers took over managing the program. At the same time Queensland Health removed the resources used to support IPS Champions within the mental health district. The decline was detected in an IPS fidelity audit conducted by the current IPS program manager who at the time, December 2017, was working as an independent contractor. This showed a marked (as high as 20%) drop in fidelity scores from the previous year. The audit also found that caseloads had declined. Fidelity scores at all sites fell below the minimum expected of 100/125 for the first time in 6 years. Several changes that help explain this decline were detected:

1. Some employment specialists were no longer co-locating with mental health teams but were visiting the mental health teams to provide updates on clients.

2. Some referred clients were being excluded because of substance use or because they did not attend appointments.

3. The IPS program was being managed differently at each location. IPS knowledge was lower and appeared to be declining further among site managers and mental health teams.

4. Clients that were no longer case managed by mental health staff were being excluded from the IPS program and were being redirected to other DES employment specialists.

5. Steering Committee meetings that previously involved both STEPS and Mental Health staff had ceased because of restructures and redistribution of roles within mental health services.

6. Regular reporting of employment outcomes back to health staff had ceased. Although the proportion of cli-

ents obtaining employment was good, at three sites this ranged from 53% to 61%, actual caseloads had declined.

7. Education placements (education outcomes also attract funding under the DES contract) were not being used to enhance employment outcomes. Of the 16 job seekers who were placed into a training course, only one job seeker went on to be placed into employment in a position relevant to the field of study.

8. Caseloads declined because of reduced referrals, low confidence in IPS among the mental health teams, and through increased early attrition. 39 participants exited because the job seeker could not be contacted, and another 20 were recorded as requesting to exit the program.

In response to the audit, STEPS management renewed their commitment to deliver a successful IPS program. The IPS Program Manager position was reestablished and commenced in late March 2018. With a renewed focus on IPS across the STEPS sites, referrals have increased, steering committee meetings have commenced on the Sunshine Coast and regular management catch-ups are occurring in Townsville and Bundaberg. Health have designated IPS "go to" case managers in each STEPS site or mental health team. New IPS progress reports are distributed monthly to mental health team leaders. New employment specialists have been recruited, inducted and provided IPS training. There has been a noticeable improvement in the program over the last 3 months.

Establishing IPS in Youth Mental Health Services Outside of the DES Program

Professor Killackey and others at the Orygen Youth Health Research Centre demonstrated that IPS could be successfully established in Australian youth mental health services outside the DES system. This involved nesting the employment service within a youth community mental health service (Killackey & Allott, 2013), which directly employs the employment specialist as a member of the case management team. This method was also investigated in two randomized controlled trials (Killackey, Jackson, & McGorry, 2008; Killackey, Allott, Jackson, Scutella, Tseng, Borland, et al., 2019). The results showed that compared with usual mental health care, the integrated employment service was more effective at getting young people experiencing early psychosis started in competitive employment.

Establishing IPS Within Headspace Services for Young People

Headspace is an Australian primary mental health service for young Australians aged 12 to 25 years established by the Australian government in 2006. The project is funded by the federal Department of Health under the Youth Mental Health Initiative Program. Headspace offers support on a range of issues including depression, anxiety, stress, alcohol and drug use, sexuality, sexual health, personal or family relationship issues and bullying. Young people and their families can get support at a headspace center as well as online and telephone support service (e-headspace). Headspace has more than 110 centers across Australia which can be accessed for free or at low cost. Staff include general medical practitioners, psychologists, social workers, occupational therapists, nurses, youth workers, counselors and alcohol and drug workers.

In the 2015 federal budget, the Department of Social Services funded a trial of High Fidelity IPS in 14 headspace locations around Australia (Australian Government, 2015). Following the initial success of this trial the Minister for Social Services announced an extension of the trial and an expansion by adding 10 new sites to the trial (Fletcher & Henderson, 2019). If successful, this trial could lead to the roll out of IPS services to all headspace centers throughout Australia. The first 14 headspace locations are included in Table 1. This trial involves the provision of external technical support and external fidelity assessment provided by practitioner experts from the Western Australian Association for Mental Health (WAAMH). The provision of external technical support for maintaining high fidelity services is an important new development in Australia that is also available to other pathways for implementing IPS.

The Importance of Advocacy

Advocacy for IPS to Be Part of Headspace Services

Professor Killackey and others at Orygen, The National Centre of Excellence in Youth Mental Health, have actively advocated for both better youth mental health services and better employment services in Australia. They have produced evidence and written about how early intervention mental health services with a focus on functional recovery could help prevent the downstream problem facing adults with severe mental illnesses of being permanently excluded from the labor force (Addington, Killackey, & Marulanda, in press; Killackey et al., 2008). A series of government inquiries confirmed these concerns (House of Representatives Standing Committee on Education and Employment, 2012; Department of Social Services, 2015; Ministerial Advisory Committee on Mental Health Workforce Participation Subcommittee, 2010) by showing that Australian service systems are not working well for young people with mental illnesses in particular. However, the lack of practical responses from governments to this evidence was especially frustrating. Appearances in parliamentary enquiries by Killackey and others informed many politicians and public officials, yet the evidence led to no substantial change in service policy or service design.

In 2013, Professor Killackey led a project to survey the current policy landscape in Australia as it related to young people with mental ill health and vocational recovery. This produced a report (Orygen Youth Health Research Centre, 2014) about the vocational outcomes for young people with mental ill health in Australia and the government policies that were meant to address this, and their shortcomings in practice. The report contained an overview of the evidence for IPS and discussed how that might be applied to youth mental health in Australia, particularly in the new headspace program. The report discussed how the headspace infrastructure could also provide evidence based IPS vocational interventions for young people. One of the report recommendations was that should the headspace trial of IPS be successful, then

the expansion of the program to adult community mental health services should be considered.

Professor Killackey and others then developed a strategy to advocate based on the content of the report. This involved national TV and radio current affairs shows, print and online media as well as making sure that every state and federal politician in the country received the report. A considerable amount of time and energy was expended on advocating directly to the government departments who could benefit most from this approach. This advocacy seemed to help, but it did not lead to change until a meeting with the Minister for Social Services. This federal department (DSS) is responsible for income support payments and welfare benefits. Once the research-based economic arguments were outlined to the Minister things began to happen. The Department asked for more detailed evidence including costing for services, duration of outcomes, the uptake and interest of young people. The Department then committed $20 million for two independent IPS trials. One trial initially involved 14 headspace sites around the country and a smaller trail targeted people with intellectual disability who received a disability support pension. In August 2018, Orygen invited the IPS practitioners to a meeting in Melbourne. It was evident at this meeting that implementation of IPS was going well in the 14 sites. Based on the discussions in Melbourne, Killackey and others met with the Minister for Social Services and the Deputy Secretary of DSS. These meetings were followed by a further commitment in January 2019 of $17 million to extend and expand the trial from 14 to 24 locations. This expansion now involves nearly one quarter of the total headspace locations, adding around 20 new IPS employment specialist positions. Independent evaluations of the IPS headspace trial are ongoing and the results will be formally reported by DSS. Once completed, these evaluations will inform further policy decisions about the role of IPS services in headspace locations.

Advocacy for a National Early Psychosis Service

In 2010, Orygen secured a tender to produce a report on the feasibility of a national early psychosis system (Orygen Youth Health Research Centre, 2011). Again, led by Professor Killackey, this project involved consulting with national and international early psychosis experts, family, consumers, mental health service managers and others. The aim was to describe the essential elements of an early psychosis system and to propose a feasible model that might be applied nationally. As a result of those consultations, particularly those with family and consumers it became obvious that a functional recovery program involving competitive employment was a necessary element of such a system.

In the 2011 federal budget funding totaling $244 million was set aside for the development of this system. So far six of these services have been set up (Melbourne, Sydney, Adelaide, Perth, Gold Coast, and Darwin). An implementation manual was developed for the early psychosis clinical program (Stavely, Hughes, Pennell, McGorry, & Purcell, 2013). This manual specifies that IPS is the model of vocational recovery to be used. A fidelity scale for the early psychosis clinical program was also developed (Killackey, 2016). In addition to the national early psychosis system, a small number of services redirected recurrent funding to IPS workers, and two Headspaces in Victoria now have IPS workers funded by a State government economic development program. Both advocacy projects were followed by significant growth in the availability of IPS services in youth mental health.

Technical Support From Western Australia

A small team at WAAMH known as IPS WORKS developed the expertise and support systems needed to establish new IPS sites throughout Australia. Led by Philleen Dickson, all team members are trained in the United States. They also support sites to develop both high fidelity and high performance. This team was successful in tendering for the ongoing support and fidelity assessment of all 14 locations in the DSS headspace trial. This expertise is also available to any organization on a fee for service basis to support new and existing IPS programs. The range of locations being supported by IPS WORKS is shown in Table 1.

Emerging Themes in Sites Supported by IPS Works Outside the DSS Trial

These seven sites attained on average 83.4% fidelity to IPS according to the IPS-25 Scale. However, 10 of 25 items had a mean score across the seven locations of less than four out of a maximum five score. These lower item level scores prompted the design of specific strategies to improve implementation fidelity at each site. For instance, strategies were developed to improve the role of IPS supervisors (Item 10); the mental health agency focus on competitive employment (Item 21); disclosure strategies (Item 13); and the quality of employer contacts (Item 18). Agencies received help to create better ways for participants to share their employment experiences, measure and report competitive employment outcomes, and use comprehensive Disclosure Worksheets. Several sites needed help to improve the frequency of employer contacts (Item 17) and help to spend more time out of the office (Item 24) in order to deliver more community-based services. One key to success at all sites appeared to be the successful appointment of an effective IPS champion within the mental health service.

Conclusion and Implications for Practice

The current situation in Australia with respect to the delivery of evidence-based employment services represents a mixed yet optimistic report card. Over the last 15 years there have been major gains in terms of government committing to funding more effective youth mental health services. However, similar progress is barely visible with respect to the reform of adult mental health services. This is because no real change to the funding and structure of adult mental health services in Australia has been proposed.

Adult mental health services continue to be funded by a complex federal–state funding model to deliver relatively short-term mental health outcomes (for a few weeks or months at most, with a primary goal involving stabilization of acute illness). These treatment goals do not yet include responsibility for vocational rehabilitation and functional recovery that can take longer, 1 to 2 years, to attain (Morgan et al., 2017; Orygen Youth Health Research Centre, 2014; Waghorn & Hielscher, 2015; Westcott, Waghorn, McLean, Strathan, & Mowry, 2015). This means that as part of each individual's treatment and recovery plan, mental health

services are permitted rather than obliged to provide assistance with vocational rehabilitation.

Similarly, DES services are permitted but not obliged to adopt IPS evidence-based practices, but they can do so within the DES funding contract, even though this contract currently provides more financial incentives for not doing so (Parletta & Waghorn, 2016; Waghorn & Hielscher, 2015). This means that adoption of evidence-based practices by employment services for adults with psychiatric disabilities currently requires the proactive engagement of both DES providers and adult community mental health teams. That this is both happening and expanding in Australia is encouraging given the multiple policy, structural, and financial disincentives that can hinder the introduction of evidence-based practices (Waghorn & Hielscher, 2015).

The main implications for practice lie within the adult mental health sector where little has been done by state or federal governments to change the status quo. Stakeholders at all levels in this sector can help promote the wider introduction of evidenced based practices particularly for those with severe mental illnesses. Mental health policymakers could help by funding services that both deliver and are responsible for functional recovery and vocational rehabilitation and not just short-cycle mental health treatment and care. DES program administrators could help by reducing the relative value of service fees (fees for enrolling and being in regular contact with participants) in favor of well-defined and transparent employment outcome fees. Many DES providers currently avoid adopting IPS practices because unrestricted caseloads and less intensive services increase revenue from service fees.

Service providers could help by attempting the transition to IPS practices, especially for clients with more severe psychiatric disabilities. With support now available from WAAMH IPS Works, this is not as challenging a transition as it may seem to providers. Finally, researchers and evaluation specialists could help service providers plan high quality evaluations of their own defined cohorts tracked over time with individual level data. This is important because the DES program administrator (DSS) is unable to report customized outcome profiles for every service provider.

Another opportunity for IPS lies in the roll-out of the new national disability insurance scheme (NDIS; National Disability Insurance Agency, 2016). This scheme is intended only for those with the more severe psychosocial disabilities and it encourages individuals to set their own vocational rehabilitation goals, including employment. Because of these program features the opportunities for IPS practices are substantial and can only increase over the next 3 years. The NDIS brings a greater focus on clients' informed choice with respect to both the nature of service to be provided, and to the clients' preferred service provider. This influence may help raise the standards for how existing services engage with and support potential service users. This development suits IPS practices because they are already designed for client centered practice and support individual preferences and decision making through all stages of the employment journey.

References

Addington, J., Killackey, E., & Marulanda, D. (in press). Early psychosis services. In A. R. Yung & P. D. McGorry (Eds.), *Youth mental health: A preventive approach to mental disorders in young people*. IP Communications.

Australian Government. (2015). *Budget paper No. 2: Budget measures 2015–16*. Retrieved from https://www.budget.gov.au/2015-16/content/bp2/html/index.htm

Bond, G. R., Drake, R. E., & Becker, D. R. (2012). Generalizability of the Individual Placement and Support (IPS) model of supported employment outside the U.S. *World Psychiatry, 11,* 32–39. http://dx.doi.org/10.1016/j.wpsyc.2012.01.005

Broadhead, P., & Galke, J. (2018, August 8–9). *Implementation of reformed DES: Opportunities to engage with the NDIS*. Workshop presented at the 2018 NESA National Conference, Brisbane, Australia.

Brooke, V., Wehman, P., Inge, K., & Parent, W. (1995). Toward a customer-driven approach of supported employment. *Education and Training in Mental Retardation and Developmental Disabilities, 30,* 308–320.

Department of Social Services. (2014). *Evaluation of Disability Employment Services 2010–2013. Final report*. Retrieved from https://d3n8a8pro7vhmx.cloudfront.net/wecanwork/pages/38/attachments/original/1436236024/DES_Evaluation.pdf?1436236024

Department of Social Services. (2015). *A new system for better employment and social outcomes. Full version of the final report*. Retrieved from https://www.dss.gov.au/review-of-australias-welfare-system/a-new-system-for-better-employment-and-social-outcomes-full-version-of-the-final-report

Fletcher, P., & Henderson, S. (2019). *Liberal-National Government's $17m boost to help young Australians with mental illness find work*. [Press release]. Retrieved from https://ministers.dss.gov.au/media-releases/4386

House of Representatives Standing Committee on Education and Employment. (2012). *Work wanted: Mental health and workforce participation*. Retrieved from https://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=ee/mentalhealth/report.htm

Killackey, E. (2016). *The EPPIC model integrity tool*. Parkville, Victoria, Australia: Orygen, The National Centre of Excellence in Youth Mental Health.

Killackey, E., & Allott, K. (2013). Utilising Individual Placement and Support to address unemployment and low education rates among individuals with psychotic disorders. *The Australian and New Zealand Journal of Psychiatry, 47,* 521–523. http://dx.doi.org/10.1177/0004867413476755

Killackey, E., Allott, K., Jackson, H. J., Scutella, R., Tseng, Y.-P., Borland, J., . . . Cotton, S. M. (2019). Individual placement and support for vocational recovery in first-episode psychosis: Randomised controlled trial. *The British Journal of Psychiatry, 214,* 76–82. http://dx.doi.org/10.1192/bjp.2018.191

Killackey, E., Jackson, H. J., & McGorry, P. D. (2008). Vocational intervention in first-episode psychosis: Individual placement and support v. treatment as usual. *The British Journal of Psychiatry, 193,* 114–120. http://dx.doi.org/10.1192/bjp.bp.107.043109

Killackey, E., & Waghorn, G. (2008). The challenge of integrating employment services with public mental health services in Australia: Progress at the first demonstration site. *Psychiatric Rehabilitation Journal, 32,* 63–66. http://dx.doi.org/10.2975/32.1.2008.63.66

King, R., Waghorn, G., Lloyd, C., McLeod, P., McMah, T., & Leong, C. (2006). Enhancing employment services for people with severe mental illness: The challenge of the Australian service environment. *The Australian and New Zealand Journal of Psychiatry, 40,* 471–477. http://dx.doi.org/10.1080/j.1440-1614.2006.01824.x

Kinoshita, Y., Furukawa, T. A., Kinoshita, K., Honyashiki, M., Omori, I. M., Marshall, M., . . . Kingdon, D. (2013). Supported employment for adults with severe mental illness. *Cochrane Database of Systematic Reviews, 9,* CD008297. http://dx.doi.org/10.1002/14651858.CD008297.pub2

Lockett, H., Waghorn, G., Kidd, R., & Chant, D. (2017). Predictive validity of evidence-based practices in supported employment. A systematic

review and meta-analysis. *Mental Health Review (Brighton), 21,* 261–281. http://dx.doi.org/10.1108/MHRJ-12-2015-0040

Marshall, T., Goldberg, R. W., Braude, L., Dougherty, R. H., Daniels, A. S., Ghose, S. S., . . . Delphin-Rittmon, M. E. (2014). Supported employment: Assessing the evidence. *Psychiatric Services, 65,* 16–23. http://dx.doi.org/10.1176/appi.ps.201300262

Ministerial Advisory Committee on Mental Health Workforce Participation Subcommittee. (2010). *Improving the workforce participation of people with severe mental illness*. Melbourne, Australia: Government of Victoria.

Morgan, V. A., Waterreus, A., Carr, V., Castle, D., Cohen, M., Harvey, C., . . . Jablensky, A. (2017). Responding to challenges for people with psychotic illness: Updated evidence from the Survey of High Impact Psychosis. *The Australian and New Zealand Journal of Psychiatry, 51,* 124–140. http://dx.doi.org/10.1177/0004867416679738

Morris, A., Waghorn, G., Robson, E., Moore, L., & Edwards, E. (2014). Implementation of evidence-based supported employment in regional Australia. *Psychiatric Rehabilitation Journal, 37,* 144–147. http://dx.doi.org/10.1037/prj0000051

National Disability Insurance Agency. (2016). *Corporate plan 2016–2021*. Retrieved from https://ndis.gov.au

Orygen Youth Health Research Centre. (2011). *Early Psychosis Feasibility Study report for the National Advisory Council on Mental Health*. Canberra, Australia: Department of Health and Ageing.

Orygen Youth Health Research Centre. (2014). *Tell them they're dreaming: Work, education and young people with mental illness in Australia*. Melbourne, Australia: Orygen Youth Health Research Centre.

Parletta, V., & Waghorn, G. (2016). The financial viability of evidence-based supported employment for people with mental illnesses in a blended funding system. *Journal of Vocational Rehabilitation, 44,* 227–241. http://dx.doi.org/10.3233/JVR-150793

Stavely, H., Hughes, F., Pennell, K., Mcgorry, P. D., & Purcell, R. (2013). *EPPIC model and service implementation guide*. Melbourne, Australia: Orygen Youth Health Research Centre.

Waghorn, G., Childs, S., Hampton, E., Gladman, B., Greaves, A., & Bowman, D. (2012). Enhancing community mental health services through formal partnerships with supported employment services. *American Journal of Psychiatric Rehabilitation, 15,* 157–180. http://dx.doi.org/10.1080/15487768.2012.679582

Waghorn, G., Collister, L., Killackey, E., & Sherring, J. (2007). Challenges to the implementation of evidence-based employment services in Australia. *Journal of Vocational Rehabilitation, 27,* 29–37.

Waghorn, G., Dias, S., Gladman, B., Harris, M., & Saha, S. (2014). A multi-site randomised controlled trial of evidence-based supported employment for adults with severe and persistent mental illness. *Australian Occupational Therapy Journal, 61,* 424–436. http://dx.doi.org/10.1111/1440-1630.12148

Waghorn, G., & Hielscher, E. (2015). The availability of evidence-based practices in supported employment for Australians with severe and persistent mental illness. *Australian Occupational Therapy Journal, 62,* 141–144. http://dx.doi.org/10.1111/1440-1630.12162

Westcott, C., Waghorn, G., McLean, D., Strathan, D., & Mowry, B. (2015). Role functioning among adults with schizophrenia. *British Journal of Occupational Therapy, 78,* 158–165. http://dx.doi.org/10.1177/0308022615573372

Received September 25, 2018
Revision received March 24, 2019
Accepted April 3, 2019 ■