Mental Health Australia

Response to Questions on Notice
Joint Standing Committee on the NDIS - Inquiry into NDIS Workforce

September 2020

1. How have the bushfires and COVID-19 highlighted inadequate access to psychosocial support workers?

The increased demand for personal mental health recovery supports due to the psychological impact of the 2019-20 bushfires and COVID-19 pandemic highlights the gap between the level of need and availability of all mental health workers – including psychosocial support workers.

Many regional communities – who were most affected by the 2019-2020 bushfires – already had reduced access to both medical and community mental health workers.[1,2] Access to skilled mental health professionals, including psychosocial support workers, to support ongoing personal recovery should be a fundamental component of disaster response. However the pre-existing under-supply of the psychosocial support workforce means it is very difficult to up-scale these services following disasters.

Similarly, the mental health impacts of the COVID-19 pandemic are extensive. The onset of COVID-19 and related loss of jobs and incomes has been associated with increased psychological distress as well as the incidence of persistent depression and anxiety.[3] Our organisations are extremely concerned that COVID-19 and the necessary restriction measures, particularly in Victoria, have exacerbated people's experience of existing severe and complex mental illness, and significantly increased the stresses faced by carers.[4]

Despite this, the psychosocial workforce who support this particularly vulnerable cohort were initially overlooked by the Government in their prioritisation of resources and workforce communications regarding pandemic responses. The sector will require further resourcing to rebuild its capacity to meet anticipated increased demand.

2. What are the challenges of digital devices and data systems in providing integrated care? What implications will these have for the workforce?

According to the Australian Academy of Technology and Engineering (ATSE), improving the capacity for data exchange between health technology systems and the ability for large-scale data analysis will be crucial in moving our health system from episodic to continuous patient care.[5] In this recent report, ATSE identified a significant skills shortage in the Australian healthcare workforce, particularly in digital literacy, as a key barrier to realising these benefits. ATSE recommends that "existing and new members of the national healthcare workforce must be supported and empowered to retrain, adapt and develop skills in line with the requirements and benefits of new digital technologies."

---

[1] Community Affairs References Committee (2018) *Accessibility and quality of mental health services in rural and remote Australia*, pp 69-70. Retrieved 21 Sept 2020 from https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MentalHealthServices/Report

[2] Mental Illness Fellowship of Australia (2018). Submission to inquiry into accessibility and quality of mental health services in rural and remote Australia. Retrieved 20 May 2020 from https://mifa.org.au/images/Documents/Submissions/1805_Submission_to_Rural_MH_Inquiry_FINAL.pdf.

[3] Fisher L (2020), Mental health of people in Australia in the first month of COVID-19 restrictions: a national survey. The Medical Journal of Australia – Pre-print – 10 June 2020 https://www.mja.com.au/system/files/2020-06/Fisher%20mja20.00841%20- %2010%20June%202020.pdf

[4] Muir, G., Beasley, A., Shackleton, F., Davis, E., Armstrong, K., Hayes, L., (2020) Caring during Coronavirus: Results of the COVID-19 Carer Survey, Caring Fairly, Melbourne.

[5] Australian Academy of Technological Sciences and Engineering Ltd. (2020) *A new prescription: Preparing for a healthcare transformation*. Retrieved 20 Sept 2020 from https://www.atse.org.au/wp-content/uploads/2020/04/ATSE-Tech-Readiness-Health_full-report.pdf

The ongoing lack of access to technology and the internet for many consumers presents a further challenge to embracing digital devices and data systems. As last measured, 1.25million Australian households (14%) were without internet access in the home. People from Culturally and Linguistically Diverse backgrounds, people who have a year 12 or below level of education, older people, people with disability, Aboriginal and Torres Strait Islander peoples and people experiencing homelessness are all less likely to have access to the internet than the general population.[6]

Psychosocial support workers have also identified that some consumers do not have the skills or confidence to navigate digital systems. The ABS Multipurpose Household Survey found that[7]:

1) Internet usage is lowest in areas with the lowest Index of Relative Socio-economic Disadvantage (IRSD) scores; and
2) among the major categories of internet usage in these areas, accessing online services for health purposes is the lowest category of use, considerably behind banking, social networking, purchasing goods or services, or entertainment.

These lower scoring IRSD areas are also those areas that the ABS 2007 survey of mental health and wellbeing identified as being areas of higher mental health need. Thus, in addition to the need for infrastructure there is also a need for home-based support to assist people develop the skills, confidence and habit of usage to be able to take advantage of online health services. Such support and training should be delivered as a component of broader in-the-community psychosocial support services.

3. The Government recently announced a Participant Service Guarantee and Independent Assessments. Do you see any workforce issues arising from these changes?

The tighter timeframes associated with the Participant Guarantee will require additional resourcing although it is difficult to estimate the impact upon the NDIS workforce without the appropriate data and modelling infrastructure. This might be better answered by the NDIA.

The introduction of Independent Assessments will require a workforce to undertake these. Most recently a tender that was offered by Services Australia estimated that 527,200 people would be expected to undergo these assessments. These assessments would be delivered over three years with 82,200 in 2020-21; 193,000 in 2021-22; and 252,000 in 2022-23.

In the Statement of Requirement is it stated that assessments will be provided by, but not limited to, speech pathologist; occupational therapist; physiotherapist; social worker; clinical psychologist; and rehabilitation counsellors. Considering the existing demands on these professions it is likely that there will be workforce shortages, particularly in rural and remote areas, that may be met with less qualified assessors undertaking this function.

[6] *Australian Digital Inclusion Index: What is the extent of the digital divide?* Retrieved from https://digitalinclusionindex.org.au/about/about-digital-inclusion/ 21 Sept 2020

[7] Australian Bureau of Statistics (2016) *8146.0 - Household Use of Information Technology, Australia, 2014-15*. Retrieved from https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/8146.0Main+Features12014-15?OpenDocument

Another major workforce issue is that the Statement of Requirement does not specify any experience or understanding of the person's presenting disability. The lack of this experience or knowledge will potentially negatively impact upon the assessment process. For people with a psychosocial disability the episodic nature of their disability needs to be understood and factored into assessments along with other variables that are consistent with their disability.

4. Are there any easy solutions to recruit workers in areas where there are significant barriers to access for people with psychosocial disability?

In our submission, we have recommended that in areas without enough NDIS psychosocial service providers to meet service demand, the Australian Government should consider block-funding "Providers of Last Resort" or hybrid models which include a block grant for basic infrastructure, with fee-for-service on top of this to promote accountability and participant choice-and-control.

In regards to increasing the psychosocial workforce in rural and remote areas where access is often an issue, governments should focus on measures to grow the local workforce. We know that people of rural origin are more likely to work in rural areas in the future. In addition to sustainability, growing the local workforce is also essential for place-based approaches and utilisation of staff who are able to understand and connect with the community's culture and experiences. There are examples in other health and social service programs of developing preferential selection, scholarship and supports for people to train and work locally.

5. Are there any practical examples you could use to explain the benefit of pre-employment training for people with psychosocial disability?

See attached response from MIFA outlining different models and evidence-base for pre-employment training.

MENTAL ILLNESS FELLOWSHIP of Australia Inc

Response to Questions on Notice
Joint Standing Committee on the NDIS - Inquiry into NDIS Workforce
September 2020

Attachment – Question 5

Are there any practical examples you could use to explain the benefit of pre-employment training for people with psychosocial disability?

Supporting people with psychosocial disability to re-enter the workforce can be complex and requires a multi-faceted response from multiple disciplines to address the unique needs of individuals. Different approaches including group centre-based programs (such as clubhouses), transitional employment programs and supported employment programs can contribute to the employment options for people with mental illness.[8] To achieve positive outcomes for individuals with psychosocial disability, we need to provide different models of pre-employment training and support that take into account people's individual needs.[9]

Group centre-based services – the Clubhouse model

The Clubhouse model is a centre-based service that provides a supportive, non-clinical environment where people with lived experience of mental illness can reconnect with the community through participation in a range of recovery-oriented activities and programs. Clubhouses offer a community of hope. The impact of the Clubhouse model is well documented.[10]

The following is extracted from *Let's get to work – A National Mental Health Employment Strategy for Australia* and provides general information about the Clubhouse model:[11]

> *A Clubhouse is a community that supports people living with mental illness. Through participation in a Clubhouse people are given the opportunity to regain friendships, relationships with family, employment, education, and access to services and support. The term "Clubhouse" was originally used to describe the first Clubhouse, Fountain House in New York City, started in 1948, and other Clubhouses that have developed over the years have followed the original model. Fountain House began when former patients of a New York psychiatric hospital began to meet together informally, forming a "club", offering a support system for people living with mental illness, rather than as a service or a treatment program.*
>
> *A Clubhouse is open to anyone with a history of mental illness and the people who participate are the members. Membership creates a sense of ownership and shared responsibility for the success of the Clubhouse, and also belonging to a supportive environment. A person with mental illness is seen as a valued*

[8] Mental Health Council of Australia, 2007. Let's get to work – A National Mental Health Employment Strategy for Australia, available at https://mhaustralia.org/sites/default/files/imported/component/rsfiles/publications/Let_s_Get_To_Work_Employment_Strategy.pdf, at p. 39.
[9] Ibid at p. 39.
[10] For the evidence, see Clubhouse International, 'Our Impact'. Available at http://clubhouse-intl.org/our-impact/overview/. Accessed: 28 September 2020.
[11] Mental Health Council of Australia, 2007. Let's get to work – A National Mental Health Employment Strategy for Australia, available at https://mhaustralia.org/sites/default/files/imported/component/rsfiles/publications/Let_s_Get_To_Work_Employment_Strategy.pdf, at p. 47.

participant and colleague, with something to contribute to the rest of the group. The design of a clubhouse engages members in every aspect of its operation. Participation is voluntary but each member is invited to participate in work including clerical duties, reception, food preparation and service, outreach, maintenance, and research.

There are several Clubhouses operating in Australia, and a number offer a range of complementary employment services in the one location including open employment, Job Network, personal support and supported education.

Group centre-based services, often referred to loosely as Clubhouses, have a valuable role to play in supporting individuals with psychosocial disability to achieve better outcomes in life. Whilst this includes assisting people with pre-employment training, skills building, job seeking skills and securing employment, these group centre-based services offer an array of additional supports to members.

A Clubhouse-type model is so beneficial because it enables people living with a mental illness to form a community of peers, experience empowerment through joint management, gain practical skills such as pre-employment training and computer skills, and support enhanced social interaction. Clubhouses strive to help members participate in mainstream employment, educational opportunities, community-based housing, wellness and health promotion activities, and activities to improve wellbeing, and social and economic participation. International research shows that Clubhouses have a 42% employment rate for members.[12] These programs result in reduced incarceration in the criminal justice system,[13] facilitate recovery-oriented practice,[14] improve education and social domain outcomes,[15] and improve quality of life, particularly with social and financial aspects of daily living.[16] Importantly, Clubhouses are low barrier to entry and provide flexible access, as members can come and go as often or as little as they please.

Clubhouse members commonly cite increased confidence, acceptance, empowerment and hope through the opportunity to engage in supportive relationships with others who share their experience,[17] highlighting the importance of peer supports in these settings. Clubhouses also provide a variety of other supports through the "functions of the house" which include helping with entitlements, housing and advocacy, promoting healthy lifestyles, as well as assistance in finding quality medical, psychological, pharmacological and substance abuse services in the community.[18]

Pre-employment training programs delivered through community centre-based services could have a significant positive effect on employment and wellbeing outcomes for individuals with psychosocial disability. McKay et al. (2018) discovered that participants within the Clubhouse model worked longer hours, and earned significantly higher wages, when compared with an assertive community treatment.[19] Clubhouse members

[12] See Clubhouse International website, available at https://clubhouse-intl.org/our-impact/overview/.

[13] Ibid.

[14] Raeburn, T., Schmied, V., Hungerford, C. and Cleary, M., 2016. The use of social environment in a psychosocial clubhouse to facilitate recovery-oriented practice. *BJPsych open*, *2*(2), pp.173-178.

[15] McKay, C., Nugent, K.L., Johnsen, M., Eaton, W.W. and Lidz, C.W., 2018. A systematic review of evidence for the clubhouse model of psychosocial rehabilitation. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(1), pp.28-47.

[16] McKay, C., Nugent, K.L., Johnsen, M., Eaton, W.W., & Lidz, C.W., 2016. A systematic review of evidence for the clubhouse model of psychosocial rehabilitation. *Administration and Policy in Mental Health and Mental Health Services Research*, 1-20.

[17] Raeburn, T., Halcomb, E., Walter, G. and Cleary, M., 2013. An overview of the clubhouse model of psychiatric rehabilitation. *Australasian Psychiatry*, *21*(4), pp.376-378.

[18] McKay, C., Nugent, K.L., Johnsen, M., Eaton, W.W. and Lidz, C.W., 2018. A systematic review of evidence for the clubhouse model of psychosocial rehabilitation. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(1), pp.28-47.

[19] Ibid.

were significantly more likely to report a higher quality of life and be in recovery than consumer-run drop-in centre participants.[20]

Centre-based services are also cost effective. For example, those who attend Clubhouses for three days or more per week have a mean one-year mental health care cost of US$5,697, compared to US$14,765 for those who attended less often.[21] Funding for one year of holistic recovery services that are delivered to Clubhouse members costs the same as a two-week psychiatric hospital stay.[22]

Unfortunately, centre-based services are poorly funded. The problem is compounded by the introduction of the NDIS and the transition of funding for centre-based services. The NDIS model does not provide the financial stability necessary for a provider to cover the fixed costs of service delivery, such as rent, electricity, rates and water. This could be somewhat alleviated by allowing centre-based services to require a 50% deposit through an NDIS package to access the service and then charge on a per use basis after this. However, the NDIS model is still not fundamentally compatible with the concept of a low barrier to entry service with flexibility of access.

Examples of programs delivered in Clubhouse-type settings

Providing pre-employment training in a Clubhouse-type setting could be beneficial for people with psychosocial disability who want to transition back to work or start working for the first time. Clubhouse programs could aid employment through transitional employment programs and supported employment programs. Below are examples of these types of programs in Australia.

Transitional Employment Programs[23]

The Transitional Employment Program is unique to the Clubhouse model and is designed to give members who lack work experience, confidence, or work skills the opportunity to work in real jobs for real pay. All members have the opportunity to access transitional employment regardless of previous work history or level of experience.

With the Transitional Employment Program the Clubhouse takes primary responsibility for the position. Clubhouse staff initially learn the job and develop comprehensive task sheets for the job. Clubhouse members are selected to participate in transitional employment based on their desire to work rather than their current skills, work experience or specific abilities. The staff provide full, on the job training and are able to offer assistance with any issue the member experiences. Staff slowly reduce their support as a member's skills and confidence grows. Throughout the entire placement, staff continue to provide regular site visits, outreach and support.

The Stepping Stone Clubhouse in Brisbane has offered a Transitional Employment Program. The main characteristics of the Stepping Stone Transitional Employment Program are:

- Positions involve 6 to 9 months of temporary work.
- Members are paid at award wages.
- Members complete the work at the employer's place of business.

[20] Ibid.

[21] Hwang, S., Woody, J. and Eaton, W.W., 2017. Analysis of the association of clubhouse membership with overall costs of care for mental health treatment. *Community mental health journal*, *53*(1), pp.102-106.

[22] Ibid.

[23] Extracted from: Mental Health Council of Australia, 2007. Let's get to work – A National Mental Health Employment Strategy for Australia, available at https://mhaustralia.org/sites/default/files/imported/component/rsfiles/publications/Let_s_Get_To_Work_Employment_Strategy.pdf, at p. 48.

- All work is entry level and does not require qualifications.
- An absence of work history and/or hospitalisation will not affect a member's chance to obtain a position.
- No résumé or interview is required as the selection process is done by Clubhouse staff and members.

Many of the members who have worked in a transitional employment position would normally be unable to find and maintain employment in the open labour market. This is mainly due to a lack of experience, relevant work skills, complications due to their mental illness, and lack of confidence. Many of these members use transitional employment to overcome these barriers and move on to more permanent work in their own job.

Supported Employment Program[24]

The Supported Employment Program is designed to assist members to obtain and keep employment of their choice. Assistance is provided with preparing résumés, writing applications and interview preparation, and members are supported in their positions once they find employment.

Support while in employment is primarily provided by staff and is based on relationships and communication with employers and members. Disclosure of illness is the decision of the employee.

Common characteristics of supported employment are:

- Competitive employment is the goal.
- Rapid job search and placement occurs.
- Vocational rehabilitation and mental health services are integrated.
- Attention is given to the person's preferences, work skills and experiences.
- Continuous assessment and ongoing support is provided by a staff member who is chosen by the member.
- The Clubhouse assists the member to learn the job and improve their skills.
- On the job support can be provided where the employer and the member agree to this.
- The Clubhouse can provide education to the employer and work colleagues about member support needs.

Stepping Stone Clubhouse has approximately 90 members, who have identified that they want to return to work and are receiving support to re-enter the workplace. Over the years, Stepping Stone Clubhouse has assisted members into more than 200 open employment placements through the Transitional Employment and Supported Employment Programs. Many of these members have moved from their first transitional employment position into other work either in other transitional employment positions or supported employment.

Getting help through the Clubhouse model – Francis' story[25]

"While I was in hospital, a case worker asked me about employment, but I didn't know what he was talking about and was too freaked out to treat the employment question

[24] Extracted from: Mental Health Council of Australia, 2007. Let's get to work – A National Mental Health Employment Strategy for Australia, available at https://mhaustralia.org/sites/default/files/imported/component/rsfiles/publications/Let_s_Get_To_Work_Employment_Strategy.pdf, at p. 49.

[25] Extracted from: Mental Health Council of Australia, 2007. Let's get to work – A National Mental Health Employment Strategy for Australia, available at https://mhaustralia.org/sites/default/files/imported/component/rsfiles/publications/Let_s_Get_To_Work_Employment_Strategy.pdf, at pp. 49-50.

seriously. After leaving hospital the doctors I saw were very good with medication and encouragement, but I don't recall ever being encouraged to work, which I suppose was a nice way of saying that I couldn't work. However since I made the realisation that paid employment was possible for a person with a psychiatric disability, my life has changed completely and for the better.

In 7 years I have moved from rehabilitation activity to volunteer work, then supported employment, and finally to my current job, a competitive employment position collecting data for psychiatric disability research. The development of routine, contact with supportive and encouraging people, a sense of progress in my skills and ability, and the knowledge that work can be deferred if illness emerges, have improved my situation enormously, both spiritually and financially. This was possible because of people with enlightened attitudes and experience with schizophrenia and employment issues, and my own determination and struggle.

I have been lucky that my skills, interests and beliefs have led me to be accepted in my current workplace. Many people I know with a psychiatric disability have a hard time finding a workplace, or even an effective rehabilitation service, and are condemned to sitting in their flat with no-one to see or nothing to do.

I became aware through my support group of a psychosocial rehabilitation program based on the Clubhouse model, called Stepping Stone, and I joined. On the first day at the clubhouse someone commended me on my good work, so I decided to come back, and kept coming back for 5 years, having fun, making friends, and improving my confidence and work skills.

After about 3 months I was chosen for a transitional employment position working in a library, and loved every minute of it. Even though transitional employment guarantees coverage for when the employee is unwell, the work had such a good effect on me that I didn't miss a day in the 6 month contract, and formed close and trusting friendships with the staff at Stepping Stone, who had more faith in me than I had in myself.

After 6 years of Clubhouse activity, including various other transitional employment positions and casual employment as an artist, I discovered a research position advertised through the Clubhouse. A support worker accompanied me to the interview, and the employer was someone I knew from conferences organised by the Clubhouse. Stepping Stone's director gave me an excellent reference. I was very happy to be selected, even surprised.

I am currently employed on a contract basis conducting telephone survey research related to role functioning of people living with a psychiatric disability. My employer has extensive knowledge of employing people with schizophrenia and I had no problem disclosing my disability.

The fact that the employment is in the field of mental health means that everyone on the job is educated on the issues involved in mental illness, which is a big help, but my employer informed me that I was chosen over applicants who did not have an illness and had better educational qualifications. Therefore, this position is in competitive employment, not sheltered employment.

I have contact with many people with psychiatric disabilities who seek competitive employment, and it is rare for them to find a job that meets their talents and skills exactly. Taking a step towards employment is always courageous, because there is

always the very real risk of relapse and hospitalisation. Fortunately, this has not happened to me.

Clubhouses within the MIFA Network

There are currently nine Clubhouse-type services (or group centre-based services) within the MIFA network of member organisations. Each program is unique to the MIFA member organisation and has been developed to meet local needs through a recovery-oriented and person-centred framework. These programs provide valuable supports to individuals with psychosocial disability to improve outcomes and quality of life. These services include the Lorikeet Centre (Mental Illness Fellowship of Western Australia in Perth), the Horizon Clubhouse (selectability in Mackay) and the Inspire Clubhouse (selectability in Townsville). MIFA can provide information about outcomes for these group centre-based services upon request.

Inspire Clubhouse (selectability)

Inspire Clubhouse in Townsville provides a non-clinical recovery setting that builds on the renowned international Clubhouse model to include contemporary recovery-oriented supports and practices. In 2019, this Clubhouse had 273 members and there were 3,397 member visits in the 2018-2019 financial year. On average, 1,100 hours of support were provided each month. Based on data compiled over the course of 3 years, 20% of Inspire Clubhouse members had secured paid employment, 10% of members had enrolled in formal training and 10% of members were volunteering in the community.

Despite their value, these services are mostly unfunded by State and Territory governments and the Federal Government. As discussed above, it is difficult to provide these services within the NDIS marketplace. MIFA member organisations continue to seek ongoing and long-term funding for these group centre-based services to ensure their financial viability and sustainability so they can remain open for the benefit of people with psychosocial disability and severe and complex mental illness.

International examples of pre-employment training

There are international examples of pre-employment training programs for people with mental illness that can be drawn upon. These include the STRIVE Program, the ACCESS Program and the Supported Employment Model: Individual Placement and Support (IPS).

The STRIVE pre-employment training program

Further information about the STRIVE Program is available here.

In the United States, the STRIVE pre-employment training program has resulted in positive employment and wellbeing outcomes for people who are unemployed and considered difficult to employ.[26]

STRIVE (Support and Training Result in Valuable Employees) is a three-week job readiness training program that targets difficult to employ adults with lower levels of educational attainment. The program aims to develop appropriate workplace behaviour, effective

[26] All information obtained about the STRIVE Program is referenced from Matt, G.E., Bellardita, L., Fischer, G. and Silverman, S., 2006. Psychological resources and mental health among the difficult-to-employ: Can a pre-employment training program make a difference? *Journal of Vocational Rehabilitation*, *24*(1), p. 33-43.

interviewing and job search techniques, and positive outlook toward working and employment. The program consists of in-class training and a variety of support services.[27]

STRIVE in-class training sessions are held for three weeks from Monday to Friday, from 9am through to 5pm, with a trainer. Through the in-class training sessions, the program aims to change self-efficacy beliefs about finding and keeping employment, to increase self-esteem, and to change dysfunctional attribution styles. The program is based on the idea that if individuals have strong efficacy beliefs, they will be more motivated and persistent in finding and keeping employment, will feel better about themselves, and will not be afraid of considering and engaging in activities previously seen as threatening (such as job interviews). Self-esteem is believed to play an important role because feelings of self-worth, self-respect, and self-acceptance will influence goal setting, job satisfaction and job performance, and will help buffer the effects of stress.

STRIVE also aims to change an individual's locus of control to increase the sense of personal control and responsibility. The goal is to change external attributions (i.e. outcomes are unpredictable or a function of chance, fate, luck and powerful others) to internal attributions. The focus is on individuals developing the sense that the outcomes of their actions are contingent on and under the control of their own behaviour or personal characteristics.

In addition to the in-class training, STRIVE offers a range of support services to participants and graduates, such as case management, job developer assistance and mental health services. Mental health counselling services are provided by an experienced and licenced psychotherapist. Program participants are offered additional individual counselling services if they choose.

In addition to personal histories of drug use, incarceration, poor job skills, and low education, applicants to the STRIVE program faced important additional obstacles to successful job-seeking and employment. Approximately half of the applicants reported clinically significant levels of depression or anxiety, characterised by worrying, apprehension, irritability, low self-esteem, hopelessness, trouble concentrating, and depressed mood.

These findings are consistent with existing literature on mental health and employment, stressing the importance of job training programs and vocational rehabilitation efforts to address important psychological factors that may interfere with job seeking behaviour and successful employment.

The Matt et al. (2006) study found that graduates of the program showed the strongest improvements with respect to self-esteem and self-efficacy. The findings indicate that men and women of different ethnic backgrounds who graduated from the three-week STRIVE program showed improvement in self-esteem, self-efficacy, attribution styles and depression. Changes in self-esteem were robust across gender and ethnic groups. Graduates showed desirable changes in attribution style, indicating more internal and less chance attribution. Consistent with improvements in self-esteem, self-efficacy and attribution styles, graduates reported a reduction in depression across all gender and ethnic groups. This is important as positive psychological health, particularly good self-esteem and self-efficacy, facilitates re-employment.[28]

To examine whether the improvements observed immediately after graduation persisted, a subsample of graduates completed follow-ups between two to eight

[27] Additional information about the STRIVE curriculum can be obtained from Scott Silverman (ssilverman@secondchanceprogram.org).

[28] Matt, G.E., Bellardita, L., Fischer, G. and Silverman, S., 2006. Psychological resources and mental health among the difficult-to-employ: Can a pre-employment training program make a difference? *Journal of Vocational Rehabilitation*, *24*(1), at p. 35.

months after graduation, showing persistent though smaller improvements compared to baseline. These findings suggest that pre-employment training programs can play a potentially important role in reducing psychological distress and strengthening psychological resources in difficult-to-employ and ethnically diverse populations trying to re-enter the workforce.

The ACCESS Program

Further information about the ACCESS Program is available here.[29]

The ACCESS Program is a supported work program designed specifically for people with severe psychiatric disability. The program was created in 1985 through the joint efforts of Transitional Employment Enterprises (TEE), the Massachusetts Alliance for the Mentally Ill, the Center for Psychiatric Rehabilitation of Boston University, and the Massachusetts Department of Public Welfare.[30]

The principles of the ACCESS Program are described as follows:

> "The Access program offers an individualized intake process; pre-employment training; placement in a paid internship; comprehensive on-the-job training and support; and, within an average of 4 to 6 months, hiring by the host employer."[31]

Trotter et al. (1988) found convincing support for the ACCESS model:

> "Both the descriptive program data and the results of the small-sample study suggest that the supported work program is indeed effective in returning individuals with severe psychiatric disability to competitive work."[32]

The Supported Employment Model: Individual Placement and Support (IPS)

Further information about the IPS Program is available here.[33]

The defining principles of the IPS model are:

- services focused on competitive employment
- eligibility based on consumer choice
- rapid job search
- integration of rehabilitation and mental health
- attention to consumer preference
- time-unlimited and individualised support.

Under the IPS model, employment programs operate in close collaboration with mental health treatment teams, whilst retaining a separate identity and mission.[34]

Bond (2004) concludes that "the evidence gleaned from a dozen studies drawn from two types of rigorous research designs shows consistent support for the effectiveness of supported employment, particularly when delivered in a high-fidelity manner."[35] He concludes that this type of model achieves a consistent pattern of positive outcomes in

---

[29] Trotter, S., Minkoff, K., Harrison, K. and Hoops, J., 1988. Supported work: An innovative approach to the vocational rehabilitation of persons who are psychiatrically disabled. *Rehabilitation Psychology*, *33*(1), p.27.

[30] Ibid at p. 29.

[31] Ibid at p. 29.

[32] Ibid at p. 33.

[33] Bond, G.R., 2004. Supported employment: evidence for an evidence-based practice. Psychiatric rehabilitation journal, 27(4), p. 345.

[34] Ibid at p. 347.

[35] Ibid at p. 356.

competitive employment. The findings show that between 40% and 60% of consumers enrolled in supported employment obtain competitive employment, while less than 20% of similar consumers do so when not enrolled in supported employment.[36]

[36] Ibid at p. 345.