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Work Wanted

Mental health and workforce participation

House of Representatives

Standing Committee on Education and Employment

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Foreword

My committee colleagues and I wish to thank everyone who participated in this inquiry.

Many people with a mental illness, their families and carers relayed their stories throughout the course of the inquiry, describing the limits illness places on educational, training and employment avenues, and the toll taken on people's lives.

The Committee especially appreciated hearing these personal accounts because they illustrate so well the barriers that exist to participation in education, training and employment for people with a mental illness. In listening to them we can start to unpeel what is required to overcome these challenges. Above all, the many individual stories attest to why a national inquiry into mental health and workforce participation is so important.

Most people want to work, and people with a mental illness are no exception.

Government services, be these employment or social services must work closely together with employer associations, employers and educational institutions to help job seekers with a mental illness find meaningful employment and pursue their educational and training goals on the paths towards that employment. Much is already being done in this space and the Committee acknowledges the multitude of community organisations that offer moral and practical support to individuals on a daily basis, to help connect them to the services they need and to find their path.

More broadly, we encourage workplaces to actively promote the mental health and well-being of all employees and foster an inclusive workplace culture.

Ms Amanda Rishworth
Chair

Membership of the Committee

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Terms of reference

Some Australians with mental ill health continue to encounter difficulties in accessing education, training and employment opportunities, and face barriers in educational institutions and the workplace. The Committee will inquire into and report on:

- barriers to participation in education, training and employment of people with mental ill health;
- ways to enhance access to and participation in education, training and employment of people with mental ill health through improved collaboration between government, health, community, education, training, employment and other services; and
- strategies to improve the capacity of individuals, families, community members, co-workers and employers to respond to the needs of people with mental ill health.

List of abbreviations

ACCI	Australian Chamber of Commerce and Industry
AHRC	Australian Human Rights Commission
AHRI	Australian Human Resources Institute
AITC	Australian Industry Trade College
ANU	Australian National University
APS	Australian Public Service
ATAPS	Access to Allied Psychological Services
AYF	Australian Youth Forum
CEDA	Committee for Economic Development of Australia
CCI WA	Chamber of Commerce and Industry Western Australia
CDU	Charles Darwin University
CITO	Continuing Inability to Work
COAG	Council of Australian Governments
CYPMH	Central Coast Children and Young People's Mental Health
DEEWR	Department of Education, Employment and Workplace Relations
DES	Disability Employment Services

DHS	Department of Human Services
DoHA	Department of Health and Ageing
DLO	Disability Liaison Officer
DMS	Disability Management Service
DSL	Dampier Salt Limited
DSP	Disability Service Pension
EAP	Employee Assistance Program
ESS	Employment Support Service
EPF	Employment Pathway Fund
EPPIC	Early Psychosis Prevention and Intervention Centre
ESat	Employment Services Assessments
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
HOPE	Health Optimisation Program for Employment
ILM	Intermediate Labour Market
IPS	Individual Placement and Support model
JCA	Job Capacity Assessment
JiJ	Jobs in Jeopardy
JSA	Job Services Australia
JSCI	Job Seeker Classification Instrument
LEAP	Local Employment Access Partnerships
LCTW	Local Connection to Work Initiative
LLNP	Language, Literacy and Numeracy Program
MHCT	Mental Health Council of Tasmania

MHFA	Mental Health First Aid
MIFSA	Mental Illness Fellowship of South Australia
MIFV	Mental Illness Fellowship of Victoria
NCVER	National Centre for Vocational Education and Training Research
NDCO	National Disability Coordination Officer
NDS	National Disability Services
NESA	National Employment Services Association
NHMRC	National Health and Medical Research Council
NMHDES	National Mental Health Disability Employment Strategy
NWP	Beyond Blue's National Workplace Program
OECD	Organisation for Economic Cooperation and Development
OT Australia	Occupational Therapy Australia
OYH	Orygen Youth Health
PBS	Place Based Services Program
PHaMs	Personal Helpers and Mentors Service
QCE	Queensland Certificate of Education
SEDIF	Social Enterprise Development and Investment Fund
SoFA	Social Firms Australia
TAFE	Technical and Further Education
SWS	Supported Wage System
TEAMhealth	Top End Association for Mental Health
VET	Vocational Education and Training

VETE	Vocational Education, Training and Employment Service
YC	Youth Connections

List of recommendations

1 Introduction

Recommendation 1

The Committee recommends that the Commonwealth Government coordinate a comprehensive and multi-faceted national education campaign to target stigma and reduce discrimination against people with a mental illness in Australian schools, workplaces and communities. The campaign should:

- include involvement from the public, private and community sectors, educational institutions, employers and a range of other stakeholders, including individuals with mental illnesses, families and carers; and
- complement existing government-funded education and awareness campaigns on depression and mood disorders, with an inclusion of psychotic illnesses.

2 Education and training

Recommendation 2

The Committee recommends that the Commonwealth Government establish a Kidsmatter High School program pilot based on similar principles to the Kidsmatter Australian Primary Schools Mental Health Initiative.

Recommendation 3

The Committee recommends that the Commonwealth Government work with peak bodies such as Universities Australia and TAFE Directors Australia to coordinate a national approach to ensure that teaching and other relevant staff at universities and vocational education institutions be educated about ways to support students with mental ill health, with access to staff professional development on mental health issues. Disability liaison officers and student services staff should be appropriately skilled to assist students with a mental illness and have access to ongoing professional development in this area.

Recommendation 4

The Committee recommends that the Commonwealth Government encourage more peer support programs on Australian university and TAFE campuses, including those that specifically support students with a mental illness.

3 Employers, employees and workplaces

Recommendation 5

The Committee recommends that the Commonwealth Government examine ways to further support social enterprises that effectively transition people with mental ill health into the open employment market.

Recommendation 6

The Committee recommends that the Commonwealth Government ensure that the Supported Wage System is sufficiently flexible to accommodate employees with a mental illness by taking into account the episodic and fluctuating nature of their condition.

Recommendation 7

The Committee recommends that the Commonwealth Government work with employer associations and employers to promote the business case for employing people with a mental illness. This should include:

- showcasing employers' broader workplace strategies for employing and retaining employees with a mental health condition and proactively promoting the mental health and well-being of all their employees as good human resource practice;

- discussion of the range of Commonwealth Government assistance available to employers;
- having employers share stories of successful placements of employees with mental ill health in their workplaces with others in their industry and the broader business community, including having 'business champions' speak about the business case for greater inclusivity; and
- jointly developing national standards for best employer awards that endorse recruiting and retaining employees with a mental illness, and promoting the mental health and wellbeing of all employees.

Recommendation 8

The Committee recommends that the Commonwealth Government support and, where necessary, amend the JobAccess, Employment Assistance Fund and Jobs in Jeopardy initiatives to ensure that:

- the scope of eligibility requirements does not prohibit employees and employers who require support; and
- ways of accessing and information about the JobAccess, Employment Assistance Fund and Jobs in Jeopardy programs and their benefits, including for employment of people with a mental illness, be clarified and readily available to employees and employers.

All these programs need to be promoted more widely and their websites kept updated.

Recommendation 9

The Committee recommends that the Commonwealth Government take a lead role in implementing best practice as an employer that looks after the mental health and wellbeing of employees, including the employment and retention of people with a mental illness.

4 Government and other service providers

Recommendation 10

The Committee recommends that the Commonwealth Government work with employment service providers to streamline assessment processes for job seekers with a mental illness and ensure that the assessment criteria for and requirements of job seekers with a mental illness are compatible and consistent across the services.

Recommendation 11

The Committee recommends that any future Disability Employment Services tender process require prospective disability employment services providers to provide evidence of expertise in working with people with mental illnesses.

Recommendation 12

The Committee recommends that the Disability Employment Services Performance Framework be monitored and evaluated on a regular and ongoing basis. DEEWR should continue to consult with a technical reference group of stakeholders to ensure the framework's and star ratings' ongoing relevance and efficacy in achieving qualitative as well as quantitative outcomes for people with mental illnesses.

Recommendation 13

The Committee recommends that DEEWR and Centrelink prioritise the implementation of a clear, effective and timely communication strategy that advises clients of the services and supports available to them, including how changes like the participation requirements and revised impairment tables will affect them.

The Committee expects that any accompanying explanatory guides and commensurate training provided to Centrelink and employment service providers by DEEWR and DHS to assist clients with mental health conditions will similarly be provided in a timely manner and user-friendly format.

Recommendation 14

The Committee recommends that any new communication strategies be developed with input from clients and staff (from both Centrelink and employment service providers) into how best to disseminate information to clients so they can readily understand any changes to their entitlement and participation requirements.

Recommendation 15

The Committee recommends that the Commonwealth Government explore ways, in partnership with the states and territories through COAG, to support Individual Support and Placement (ISP) and other service models that integrate employment services and clinical health services.

1

Introduction

There is ample evidence of the benefits of work for people with mental illness and that most people with a mental illness want to work.[1]

Work is the best therapy for me...it is vital to that road to recovery.[2]

Working means the world to me...it gives me something to do [and] look forward to.[3]

The issue – increasing numbers of people with a mental health condition on income support

Statistics

1.1 In the 2007 Australian Bureau of Statistics *National Survey of Mental Health and Wellbeing* 45 per cent of Australians aged 16-85 years reported experiencing at least one, or a combination of, mental illnesses at some point in their lifetime. And 20 per cent of Australians reported

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1 Comcare, *Submission 64*, p. 1.

2 Scott, personal communication to Mental Illness Fellowship of Australia, March 2005, in Geoff Waghorn and Chris Lloyd, 'The employment of people with a mental illness' *Australian eJournal for the Advancement of Mental Health,* 2005.

3 Mental health consumer, in NSW Consumer Advisory Group, *Submission 42*, p. 2.

experiencing one or a combination of mental disorders in the previous 12 months.[4]

1.2 Mental illness is the single largest cause of disability in Australia.[5] According to the Australian Institute of Health and Wellbeing:

> Mental disorders account for 13.1 per cent of Australia's total burden of disease and injury and are estimated to cost the Australian economy $20 billion annually in lost productivity and labour participation.[6]

1.3 The 2007 Organisation for Economic Cooperation Development's (OECD) report titled *Sickness, Disability and Work (Vol. 2): Australia, Luxembourg, Spain and the United Kingdom* (the OECD report) notes a large increase in the last 15 years in the number of working-age people receiving disability benefits in Australia.[7]

1.4 A joint submission from the Commonwealth departments of Education, Employment and Workplace Relations (DEEWR), Health and Ageing (DoHA) and Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) (hereafter referred to as the joint department submission) states that income support payments through the Disability Support Pension (DSP) are the single largest outlay of welfare benefits for Australians experiencing mental illness.[8]

1.5 The Centrelink website sets out the eligibility criteria for receiving DSP. Claimants must be:

- 16 years of age or over at the time of claiming and under age-pension age;
- Assessed as having a physical, intellectual or psychiatric impairment of at least 20 points [against Impairment tables] and are either:
  - ⇒ Participating in the Supported Wage System, or
  - ⇒ Unable to work or be retrained for work of at least 15 hours or more per week at or above the relevant minimum wage within the next two years because of their impairment, and

4 Australian Bureau of Statistics, 2008, *2007 National Survey of Mental Health and Wellbeing: Summary of Results* (cat. No. 4326.0), ABS, Canberra.

5 Department of Education, Employment and Workforce Participation, *Submission 62*, p. 3.

6 Australian Institute of Health and Welfare, 2007, *The burden of disease and injury in Australia,* 2003, AIHW, Canberra.

7 OECD, *Sickness, Disability and Work: Breaking the Barriers,* Vol. 2: Australia, Luxembourg, Spain and the United Kingdom, 2007, p. 13.

8 DEEWR, DoHA and FaHCSIA, *Submission 62*, p. 3.

> assessed as having either a severe impairment or as having actively participated in a program of support.[9]

1.6 The advantage of a DSP benefit, over other types of benefits such as Newstart or Youth Allowance, is the higher benefit payment. For instance, a single person aged over 21 years on the DSP without children may receive a maximum fortnightly payment of $695.30 as compared with $489.70 a fortnight on Newstart and $402.70 a fortnight on Youth Allowance.[10]

1.7 Data presented by FaHCSIA showed that in the last decade the numbers of DSP recipients with a psychiatric or psychological condition recorded as their primary condition has grown by some 76.1 per cent. Of the approximately 793,000 DSP recipients at June 2010, nearly a third, 28.7 per cent (approximately 227,000), had a mental illness as their primary condition. DSP expenditure for people experiencing a mental illness in 2009-2010 was estimated at $3 billion. These numbers do not include people on other types of benefits, such as Newstart allowance or Parenting Payment, who may also have a mental illness as a barrier to participation.[11]

1.8 The updated FaHCSIA document *Characteristics of Disability Support Pension Recipients* (June 2011) reports a small increase of DSP recipients in the psychological/psychiatric category (29.5 per cent) and notes:

> The proportion of DSP recipients with a *Psychological/Psychiatric* primary medical condition surpassed *Muscluo-skeletal and connective tissue* for the first time in 2011.[12]

1.9 The 2007 OECD report found that employment rates of Australians with a disability stands at around 40 per cent, which is lower than five years ago and only half the rate of those without a disability.[13]

1.10 While Australia has enjoyed high rates of economic growth for more than a decade and the unemployment rate has fallen as low as 4.3 per cent, the

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9 Centrelink website, http://www.centrelink.gov.au/internet/internet.nsf/payments/dsp_eligible.htm

10 See Centrelink website for details. http://www.centrelink.gov.au/internet/internet.nsf/payments/dsp_eligible.htm, http://www.centrelink.gov.au/internet/internet.nsf/payments/newstart_rates.htm and http://www.centrelink.gov.au/internet/internet.nsf/payments/ya_rates.htm#amount

11 Characteristics of Disability Support Pension Recipients, June 2010, FaHCSIA in DEEWR, DoHA and FaHCSIA, *Submission no. 62*, p. 3.

12 FAHCSIA, Characteristics of Disability Support Pension Recipients, June 2011, p. 6.

13 OECD, *Sickness, Disability and Work: Breaking the Barriers,* Vol. 2: Australia, Luxembourg, Spain and the United Kingdom, 2007, p. 19.

living conditions of those with a disability has not improved.[14] The incomes of Australians with disabilities are about 15 per cent lower than the national OECD average.[15]

1.11 Despite average health status improvements in OECD countries, there is a growing trend of people reporting mental health conditions and their low market participation rates. This issue is a key policy challenge for all OECD governments, including the Australian Government.[16]

1.12 While mental health and disability, social welfare and workforce participation are topics that have all received considerable policy attention in recent years, there has been something of a gap in focusing specifically on the employment prospects of persons with a mental illness.

1.13 Given the statistics on the sheer numbers of people affected by a mental illness receiving the DSP it is timely to look more closely at the issue. This is the first Australian parliamentary committee inquiry to look specifically into the nexus between mental health and workforce participation.

Filling workforce shortages

1.14 At the same time as the numbers of people with a mental health condition on the DSP are increasing, it is well-documented that Australia must redress an ageing workforce[17] with workforce shortages in parts of rural and regional Australia in various sectors that include health professionals, teachers and the trades.[18]

1.15 The resources industry is perhaps the most obvious example of a sector that will need more workers to cope with anticipated demand into the future. The National Resources Sector Employment Taskforce Report titled *Resourcing the Future (*July 2010), chaired by then Parliamentary Secretary for Western and Northern Australia, the Hon. Gary Gray AO,

14 OECD, *Sickness, Disability and Work: Breaking the Barriers,* Vol. 2: Australia, Luxembourg, Spain and the United Kingdom, 2007, p. 19.

15 OECD, *Sickness, Disability and Work: Breaking the Barriers,* Vol. 2: Australia, Luxembourg, Spain and the United Kingdom, 2007, p. 19 and DEEWR, DoHA and FAHCSIA *Submission 62,* p. 4.

16 OECD, *Sickness, Disability and Work: Breaking the Barriers,* Vol. 2: Australia, Luxembourg, Spain and the United Kingdom, 2007, p. 19 and DEEWR, DoHA and FAHCSIA *Submission 62* p. 4.

17 See Australian Government, *Australia to 2050: future challenges – the 2010 intergenerational report OVERVIEW*, p.4, http://www.treasury.gov.au/igr/igr2010/Overview/pdf/IGR_2010_Overview.pdf

18 Various reports document this trend. See the Department of Transport and Regional Services Bureau of Transport and Regional Economics report, *Skills Shortages in Regional Australia*, Working paper no. 68., 2006 for one analysis, http://www.bitre.gov.au/publications/19/Files/wp68.pdf

MP, referred to 75 major resources projects expected to commence in Australia over the next five years and the need for tens of thousands more workers in both their construction and operational phases. Existing and anticipated shortages span a diverse range of professions, trades and other skills, including mining engineers, geoscientists, drillers, electrical trades, mechanical technicians, machinery operators and drivers.[19]

1.16 The Australian Bureau of Statistics reported that the mining hubs of Western Australia and Queensland posted a rise in job vacancies in the year to November 2011.[20]

1.17 The mining company BHP Billiton estimates that the resources industry will need more than 150,000 extra workers in the next five years.[21]

Upskilling: a mainstream issue

1.18 The Commonwealth Government encourages upskilling the Australian population as a whole. Complementing the Government's 'Building Australia's Future Workforce' initiative, a National Workforce Development Fund will provide $558 million over four years to industry to support training and workforce development in areas of current and future workforce need.[22]

1.19 One of the Fund's current three priority areas is to support the resources sector, with attention focused on where workforce shortages are the most acute.[23]

1.20 The new Skills Connect website is a service designed to:

> link eligible Australian enterprises with a range of skills and workforce development programs and funding....[24]

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19 Australian Government, *Resourcing the Future: National Resources Sector Employment Taskforce Report,* July 2010. See pp. 14, 18 and p. 39.

20 Clancy Yeates, 'Non-mining states feeling the pinch', *Sydney Morning Herald*, 12 January 2012, p. 21.

21 ABC News, The World Today, Stephen Dziedzic, '*Miners sound warning on skills shortage*', September 29, 2011.

22 See the National Workforce Development Fund website for more details: http://www.deewr.gov.au/Skills/Programs/SkillTraining/nwdf/Pages/default.aspx viewed 21 February 2012.

23 See the National Workforce Development Fund website for more details: http://www.deewr.gov.au/Skills/Programs/SkillTraining/nwdf/Pages/default.aspx viewed 21 February 2012.

24 Skills Connect website, http://www.skills.gov.au/SkillsConnect

Policy framework and strategies

1.21 The 2007 OECD report made policy recommendations in the following three areas:

- strengthening employer involvement in the early phase of a health condition;
- ensuring everybody who could benefit from employment services can get them; and
- reform of benefits to improve work incentives and increased incomes.[25]

1.22 A later report by Rachel Perkins, Paul Farmer and Paul Litchfield titled *Realising Ambitions: Better employment support for people with a mental health condition*, which was prepared for the Department of Work and Pensions in the United Kingdom in 2009, made a number of recommendations in three broad categories to the UK Government:

- increasing capacity and dispelling myths within existing structures so that they are better able to meet the needs of people with a mental illness;
- "model of more support": implementing Individual Placement and Support; and
- establishing effective systems for monitoring outcomes and driving change.[26]

1.23 A more recent OECD report titled, *Sick on the Job? Myths and Realities about Mental Health and Work*[27] notes new evidence that:

> ... questions some of the myths and taboos around mental ill-health and work. People with a severe mental disorder are too often too far away from the labour market, and need help to find sustainable employment. The majority of people with a common mental disorder, however, are employed but struggling in their jobs. Neither are they receiving any treatment nor any supports in the workplace, thus being at high risk of job loss and permanent labour market exclusion. This implies a need for policy to shift away from severe to common mental disorders and sub-threshold

25 OECD, *Sickness, Disability and Work: Breaking the Barriers,* Vol. 2: Australia, Luxembourg, Spain and the United Kingdom, 2007, pp. 21-23.

26 Rachel Perkins, Paul Farmer and Paul Litchfield, *Realising ambitions: Better employment support for people with a mental health condition,* a review to Government, December 2009, Stationary Office, UK., http://www.dwp.gov.uk/policy/welfare-reform/legislation-and-key-documents/realising-ambitions/

27 OECD, *Sick on the Job? Myths and Realities about Mental Health and Work*, December 2011, http://www.oecd.org/document/20/0,3746,en_2649_33933_38887124_1_1_1_1,00.html

> conditions; away from a focus on inactive people to more focus on those employed; and away from reactive to preventive strategies.[28]

1.24 Supporting people who are currently in the workforce and experiencing mental ill health to retain their employment is as important as enhancing access to jobs and training for those looking to enter into employment.

1.25 The Committee's inquiry and report is informed by the principles that underpin these reports and considers these principles as they apply in the Australian context.

1.26 As previously indicated, much has been and is happening within the spaces of mental health and workforce participation respectively.

1.27 It is not within the remit of this report to propose fundamental reform to either mental health or welfare sectors. The Senate Select Committee on Mental Health conducted a comprehensive mental health services inquiry in 2006[29] and this Committee does not seek to repeat that work. Neither will it propose major overhauls of the social welfare system. These much broader debates have been and are still taking place in other forums.

1.28 This report is specifically about the barriers to workforce participation for people with mental ill health and the ways to best overcome them.

1.29 The report presents the key issues repeatedly raised during the inquiry, highlights best practice, and suggests ways forward to capitalise on gains and build momentum to make long-lasting improvements.

Benefits of employing people and keeping them in employment

1.30 The 2007 OECD report asserts that helping people with mental ill health to work is a win-win scenario:

> It helps people avoid exclusion and have higher incomes while raising the prospect of more effective labour supply and higher economic output in the long term.[30]

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28 Chapter 6, Summary and Conclusions in OECD, *Sick on the Job? Myths and Realities about Mental Health and Work*, December 2011, http://www.oecd.org/document/20/0,3746,en_2649_33933_38887124_1_1_1_1,00.html, p. 199.

29 Senate Select Committee on Mental Health website, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=mentalhealth_ctte/index.htm.

30 OECD, *Sickness, Disability and Work: Breaking the Barriers,* Vol. 2: Australia, Luxembourg, Spain and the United Kingdom, 2007, p. 19 and DEEWR, DoHA and FAHCSIA, *Submission 62,* p. 3.

1.31 Throughout the course of the inquiry, the Committee heard many success stories relating the benefits of employing and retaining employees who had experienced mental ill health, for both employees and employers.

1.32 Mr Gary Wanstall described the difference that having a job had made to his life, and alluded to the importance of early intervention and understanding of the episodic nature of his illness from his long-standing employer in Western Australia. His case exemplifies how an employer, an employment service provider and a clinician can work together to tailor employment to the individual's situation and benefit everyone involved:

> At the end of 2009, I had another episode and ended up in hospital again. I did not know what to do with my life...Edge Employment, St John of God Hospital and my psychiatrist got together and they created a [new] job for me [after having previously held different jobs at the hospital over a number of years].
>
> I admit patients. I take them up to their rooms and introduce them to the hospital, St John of God hospital, Murdoch. It is the best job in the hospital and I love it. I think I do a good job. I love getting up every morning and going to work. I feel very lucky and very privileged to have Edge Employment, St John of God Hospital and the support system that I have with me, which I am very happy with...I feel worthwhile; I feel like I'm doing something...I feel normal, which is good.[31]

1.33 Mr Wanstall added:

> I think if my CEO were here now, he would put me up on a pedestal and tell you how well I do at work.[32]

1.34 Rio Tinto spoke of its commitment to supporting existing employees and their families, when an employee suffers from a mental illness, and pointed to a range of available policies and programs. Further, Rio affirmed its engagement with finding new ways to help the workforce manage mental health and resilience by building and sustaining a supportive and healthy working culture.[33]

1.35 Anecdotal evidence suggests that there may be a greater loyalty to workplaces from employees who support staff in this manner.

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31 Mr Gary Wanstall, *Committee Hansard*, 18 October 2011, Perth, p. 23.

32 Mr Gary Wanstall, *Committee Hansard,* 18 October 2011, Perth, p. 23.

33 Dr Andrew Porteous, Corporate Health and Safety, Rio Tinto, *Committee Hansard*, 18 October 2011, Perth, p. 7.

1.36 Mr Rhett Foreman, General Foreman at Abigroup Inc. intimated that Abigroup's proactive approach to mental health had been a factor in his acceptance of a position at that company:

> That certainly tilted things in Abigroup's favour, from my point of view, [despite my having had other job offers].

1.37 The Australian Chamber of Commerce and Industry (ACCI) advised that while there was no hard research to support that this would be the case:

> It would make sense that where an employee has found an understanding employer and where an employer values that employee I would think that would be far more likely to be long term [loyalty to the employer] and that is a benefit.[34]

Mental health reforms

1.38 Significant resources have been devoted to reforms in the mental health and workforce participation spaces respectively in recent years. It is useful to background some of these reforms before moving on to consider the intersection between mental health and workforce participation.

1.39 Professor Patrick McGorry AO, 2010 Australian of the Year and Chief Executive Officer of Orygen Youth Health – a world renowned mental health organisation for young people – noted that we are at a tipping point for mental health reform in Australia:

> Not only can we no longer afford to do nothing, but we now have the opportunity, capacity and momentum to deliver genuinely transformational change... to live in communities in which people are increasingly enlightened about mental health issues and where locally based services respond early, expertly and effectively whenever we begin to struggle with mental health.[35]

1.40 The Prime Minister, the Hon. Julia Gillard MP, has indicated that mental health reform is a key priority for the Commonwealth Government. In 2010 the first Commonwealth Minister for Mental Health, the Hon. Mark Butler MP, was appointed to affirm this focus. The 2010-2011 and 2011-2012 budgets reflected this commitment with a $2.2 billion mental health reform package to be delivered over five years for mental health services.[36]

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34 Ms Jennifer Lambert, ACCI, *Committee Hansard*, 14 October 2011, Canberra, p. 46.

35 Website of Professor Patrick McGorry, Australian of the Year 2010, http://www.patmcgorry.com.au/

36 Department of Health and Ageing, *Australian Government 2011-2012 Health and Ageing Portfolio Budget Statements, Mental health*, p. 309,

1.41 The 2011-2012 Budget contained $1.5 billion for new measures and improving existing ones. The priorities are:

- providing more intensive support services, and better coordinating those services for people with severe and persistent mental illness;
- targeting support to areas and groups that need it most, such as Indigenous communities and socioeconomically disadvantaged areas that are underserviced by the current system; and
- helping to detect potential mental health problems in the early years and supporting young people who struggle with mental illness.[37]

1.42 The Parliamentary Library Budget review, *Mental health – centrepiece of this year's health budget,* highlights some of the significant measures in the 2011-2012 Budget:

- $419.7 million over five years to establish up to 12 new Early Psychosis Prevention and Intervention Centres (EPICC), and 30 new *headspace* sites to help young people with or at risk of mental illness;
- $343.8 million over five years to provide more coordinated care services to people with severe mental illnesses;
- $269.3 million over five years for community mental health services, in particular to expand Family Mental Health support services and increase the number of personal helpers, mentors, and respite care services;
- $201.3 million over five years for a National Partnership Agreement on Mental Health. Funds from this agreement would be made available to state and territory governments on a competitive basis for projects designed to address major gaps in mental health services ;and
- $205.9 million over five years to expand access to the Access to Allied Psychological services programs in hard to reach and low socioeconomic areas.[38]

1.43 Other important initiatives include the establishment of a Mental Health Commission and an online portal that will make it easier for people to find

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http://health.gov.au/internet/budget/publishing.nsf/Content/2011-12_Health_PBS_sup2/$File/2011-12_Health_PBS_17_Outcome11.pdf

37 Department of Health and Ageing, *Australian Government 2011-2012 Health and Ageing Portfolio Budget Statements, Mental health*, pp. 312-315, http://health.gov.au/internet/budget/publishing.nsf/Content/2011-12_Health_PBS_sup2/$File/2011-12_Health_PBS_17_Outcome11.pdf

38 Parliament of Australia, Parliamentary Library, *Budget 2011-12: Mental Health – centrepiece of this year's health budget,* http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201112/Mental

and access mental health services.[39] The National Mental Health Commission was launched on 23 January 2012.[40]

1.44 At its meeting on 19 August 2011, the Council of Australian Governments (COAG) agreed to commence work on the development of a National Partnership Agreement on Mental Health to address priority service gaps in Australia's mental health system, and to develop a Ten Year Roadmap for National Mental Health Reform that will set out the main steps to achieving this vision. The draft roadmap was released on 17 January 2012, with comments currently being sought from interested parties.[41]

1.45 The national partnership and roadmap operate in the context of COAG's fourth national mental health plan: an agenda for collaborative government action which covers the period from 2009 through 2014.[42]

1.46 In Australia states and territories are responsible for the provision of clinical health services. This means that health services differ between jurisdictions. As a result, the extent to which services join seamlessly varies and there can be silo effects with service delivery.

Welfare reforms

1.47 Efforts to improve Australia's welfare system has been another priority for the Australian Government.

1.48 On 11 August 2010, the Commonwealth Government announced its intention to:

- spread the dignity and purpose of work;
- end the corrosive aimlessness of welfare; and
- bring more Australians into mainstream economic and social life.[43]

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39 Parliament of Australia, Parliamentary Library, *Budget 2011-12: Mental Health – centrepiece of this year's health budget.*

40 See the website for details of the Commission's role and meetings: http://www.mentalhealthcommission.gov.au

41 The Hon. Jenny Macklin MP, Minister for Families, Community Services and Indigenous Affairs and Minister for Disability Reform and The Hon. Mark Butler MP, Minister for Mental Health and Ageing, Minister for Social Inclusion, Minister Assisting the Prime Minister on Mental Health Reform, 'A New Ten Year Plan for Mental Health', *joint media release*, 17 January 2012, http://www.jennymacklin.fahcsia.gov.au/mediareleases/2012/Pages/plan_for_mental_health_170112.aspx viewed 21 February 2012.

42 See Department of Health and Ageing website for the plan in full, http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-f-plan09#pla

1.49 The Commonwealth Government's policy consists of 'carrots' that connect people to jobs (including offering relocation assistance to unemployed Australians prepared to relocate to take up work), and 'sticks' that impose tougher rules on jobseekers and strengthen compliance.[44]

1.50 Proposals for tougher rules for jobseekers, that is, the ability to suspend social security payments for job seekers if they fail to attend appointments with job service providers, was the subject of inquiry and an advisory report on the Social Security Legislation Amendment (Job Seeker Compliance) Bill 2011 by this Committee, which was tabled in May 2011.[45]

1.51 To further these initiatives, the Commonwealth Government announced a $3 billion package, 'Building Australia's Future Workforce' in the 2011-2012 Budget.[46] The Government intends the package to:

- reward work through improved incentives in the tax and transfer system;
- provide new opportunities to get people into work through training, education, and improved childcare and employment services;
- introduce new requirements for the very long-term unemployed, Disability Support Pensioners, teenage parents, jobless families and young people; and
- take new approaches to address entrenched disadvantage in targeted locations.[47]

1.52 The Parliamentary Library budget review, *Disability support pension - reforms*, highlights the key changes. An important new measure is:

- allowing [DSP] recipients who are subject to the 15 hours a week requirements to work for up to 30 hours a week and remain eligible for a part-rate pension.[48]

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43 Prime Minister the Hon. Julia Gilliard MP, 'Modernising Australia's Welfare System', 11 August 2010, http://www.alp.org.au/getattachment/0d1c1c6d-e83b-434e-873f-9f2ea269f5ab/modernising-welfare/

44 Prime Minister the Hon. Julia Gilliard MP, 'Modernising Australia's Welfare System', 11 August 2010, http://www.alp.org.au/getattachment/0d1c1c6d-e83b-434e-873f-9f2ea269f5ab/modernising-welfare/

45 House of Representatives Standing Committee on Education and Employment, *Advisory Report on the Social Security Legislation Amendment (Job Seeker Compliance) Bill 2011,* May 2011, Canberra.

46 Treasury, Building Australia's Future Workforce, Commonwealth of Australia 2011, http://cache.treasury.gov.au/budget/2011-12/content/download/glossy_skills.pdf

47 Department of Human Services, Centrelink website, Building Australia's Future Workforce, http://www.humanservices.gov.au/corporate/government-initiatives/building-australias-future-workforce

48 Parliament of Australia, Parliamentary Library, *Budget 2011-12: Disability support pension – reforms,*

1.53 Other changes include:

- improving work capacity assessments for DSP claimants; and
- providing personal helpers and mentors specifically to help people with mental illness who are participating in employment services and who are on, or in the process of claiming income support, including the DSP.[49]

1.54 The Parliamentary Library review outlines some of the initiatives to support pension recipients into work:

- $558.5 million over four years for a National Workforce Development Fund to support relevant, industry-based training in areas of skill shortage;
- $143.1 million over four years for up to 30,000 additional Language, Literacy and Numeracy Program training places;
- $133.3 million over four years for very long-term unemployed job seekers to undertake approved Work Experience Activities for 11 months of the year (rather than six months under the current scheme);
- $11.3 million over three years for wage subsidies to be paid to employers who provide employment placements to people with disability who have been unemployed for at least 12 months;
- $94.6 million over four years for wage subsidies for employers of very long-term unemployed job seekers to provide paid employment experience to help them transition into paid employment;
- $21.8 million over three years for an awareness campaign that promotes the benefits of employing the very long-term unemployed and people with a disability; and
- $35.3 million over four years for measures that streamline services for job seekers (as part of the Government's response to the Independent Review of the Job Seeker Compliance Framework).[50]

Intersection of mental health and workforce participation reforms

1.55 The preceding section outlines the reforms in the mental health and welfare/workforce participation spaces in recent years.

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http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201112/Disability

49 Parliament of Australia, Parliamentary Library, *Budget 2011-12: Disability support pension – reforms.*

50 Parliament of Australia, Parliamentary Library, *Budget 2011-12: Workforce participation measures,* http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201112/Workforce

1.56 Clearly, there is overlap between the two with regards to encouraging and supporting job seekers with a mental illness to participate in education, training and employment.

1.57 As part of its broader Social Inclusion Agenda,[51] the Government released a National Mental Health and Disability Employment Strategy (NHMDES) in September 2009.[52]

1.58 The NMHDES aims to address the barriers faced by people with a disability, including mental illness, that make it harder for them to gain and keep work.

1.59 The NMHDES recognises the importance of education and training as a pathway to sustainable employment, and the role of employers in increasing employment opportunities for people with disability.[53]

1.60 Highlights of the Strategy include:

- new Disability Employment Services to give job seekers immediate access to personalised employment services better suited to their needs with stronger links to skills development and training;
- a DSP Employment Incentive Pilot that will provide job opportunities for 1,000 Australians who receive the DSP;
- the Australian Public Service Commission will develop training and best practice advice for Australian Public Service (APS) agencies and managers, and establish and support disability networks for APS Human Resources Managers and practitioners;
- improved assessment and support for people with a disability. Changes to the Job Capacity Assessment (JCA) process that ensure that people on DSP who want help to find work will no longer have to worry about putting their disability pension on the line;
- workforce re-engagement through better and fairer assessments for DSP. A number of measures will support the re-engagement of people with disability within the workforce as part of the Disability Pension- better and fairer assessments 2009-2010 Budget measure;

51 See the Australian Government Social Inclusion website for more, http://www.socialinclusion.gov.au/

52 See the Department of Education, Employment and Workplace Relations website for the Strategy, http://www.deewr.gov.au/Employment/Pages/NMHDES.aspx

53 DEEWR website, http://www.deewr.gov.au/Employment/Pages/NMHDES.aspx and FaHCSIA website, http://www.facs.gov.au/sa/mentalhealth/progserv/Pages/NationalMentalHealthDisabilityEmploymentStrategy.aspx

- the creation of a new Employment Assistance Fund that will bring together resources from the Workplace Modifications Scheme and the Auslan for Employment Program making it easier for employers, people with a disability and employment providers to access assistance;
- an Innovation Fund will help more people with disability into jobs by funding innovative projects that remove barriers to employment; and
- an enhanced JobsAccess website to increase awareness among employers of the services available to support both people with disability and mental illness.[54]

1.61 The NHMDES is supported by – and to some extent now superseded by – the Government's more recent National Disability Strategy, which was the result of an extensive nation-wide consultation process. In February 2011, COAG formally endorsed a 10 year national policy framework to guide government activity and drive future reforms to improve outcomes for people with a disability, including mental illness.[55]

1.62 The purpose of the 2010-2020 National Disability Strategy is to:

- establish a high level policy framework to give coherence to, and guide government activity across mainstream and disability-specific areas of public policy;
- drive improved performance of mainstream services in delivering outcomes for people with disability;
- give visibility to disability issues and ensure they are included in the development and implementation of all public policy that impacts on people with disability; and
- provide national leadership toward greater inclusion of people with disability.[56]

1.63 One of the priority areas for action is:

> economic security – jobs, business opportunities, financial independence, adequate income support for those not able to work, and housing.[57]

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54 DEEWR website, http://www.deewr.gov.au/Employment/Pages/NMHDES.aspx. It is worth noting that as of October 2010 there has been a Social Inclusion Minister and a dedicated Australian Government Social Inclusion Agenda website, http://www.socialinclusion.gov.au/

55 Available from the FaHCSIA website, http://www.facs.gov.au/sa/disability/progserv/govtint/nds_2010_2020/Pages/default.aspx

56 FaHCSIA website, National Disability Strategy, http://www.facs.gov.au/sa/disability/progserv/govtint/nds_2010_2020/Pages/default.aspx#2

The stigma of mental ill health

1.64 The reforms in mental health and workforce participation policies and programs occur against a background that is slower to change, that is, the stigma associated with mental ill health.

1.65 Stigmatisation of mental ill health is based on ill-informed assumptions such as people with mental ill health have limited capacity or will to participate or they will be disruptive and dangerous.

1.66 Stigma can come from employers, colleagues, clinicians, family, friends and the wider community and, perhaps most debilitating of all, can manifest as self-stigma. One of the main adverse consequences of stigmatising people with mental ill health is an increased reluctance for them to disclose their mental health issues and associated needs.

Stigma in the workplace

> 'When you have a mental illness, employers think of you as a liability. Some of them think that you're likely to be an axe-murderer.'[58]

1.67 Negative and misinformed attitudes toward people with mental ill health create barriers to work by either preventing entry, or by making a person's time in the workplace more difficult than it would otherwise be.

1.68 Employers may be hesitant to engage an employee with mental ill health because of a sporadic work history or concern at potential management issues. Witnesses reported that disclosing mental ill health lowered the likelihood of selection for interview or appointment to the position.[59] Stigma can also present during interviews. Ms Bernette Redwood, Executive Officer, Vista Vocational Services, related an incident when she accompanied a consumer to a job interview:

> ... while we were there the person who interviewed them basically took the ruler and the scissors off the desk and put them in a

57 FaHCSIA website, National Disability Strategy, http://www.facs.gov.au/sa/disability/progserv/govtint/Pages/nds.aspx#1

58 Ms Julie Hourigan-Ruse, Chief Executive Officer, New South Wales Consumer Advisory Group, *Committee Hansard*, 17 June 2011, p. 37.

59 For instance, Miss A, Ex Client of Orygen Youth Health, *Committee Hansard*, 13 April 2011, p. 14; Mrs Hiltrud Kivelitz, Mental Health Coordinator, Carers NT, *Committee Hansard*, 17 October 2011, p. 11.

> drawer. I do not know whether he thought we were going to attack him or something.[60]

1.69 Employers and managers need practical strategies to support employees through periods of unwellness. Ms Therese Fitzpatrick, National Workplace Program Manager, Beyond Blue, reported that employers may not understand that people often want to continue working, and that employers and co-workers often do not know how to support them to do that.[61]

1.70 Representatives from the New South Wales Consumer Advisory Group reported comments from consumers who had disclosed mental ill health to their employer and co-workers:

> ... 'they asked me if I was aware of my actions all of the time.'
>
> ... [I was treated as] 'an out-of-control weirdo'...
>
> ... [they] 'initially suggested medical retirement ... I remain appalled at their reaction and still feel the stigma because of it.'[62]

Stigma amongst clinicians

1.71 Some of those charged with diagnosis and expert care of people with mental ill health are not immune to unfounded and incorrect assumptions associated with these conditions. The authority accorded to clinicians who are not fully aware of the benefits of work to sufferers of mental ill health can reinforce stigma circulating in the broader community.

1.72 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, described how people with severe mental illness, such as schizophrenia, were traditionally not expected to return to work. Dr Groves indicated this traditional view can mean that clinicians may also present a significant barrier to participation.[63]

1.73 Ms Laura Collister, General Manager, Rehabilitation Services, Mental Illness Fellowship Victoria, stated that prior to a partnership with her

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60 Ms Bernette Redwood, Executive Officer, Vista Vocational Services, *Committee Hansard*, 13 May 2011, p. 15.

61 Ms Therese Fitzpatrick, National Workplace Program Manager, Beyondblue, *Committee Hansard*, 19 August 2011, p. 2.

62 Ms Julie Hourigan-Ruse, Chief Executive Officer, New South Wales Consumer Advisory Group, *Committee Hansard*, 17 June 2011, p. 37.

63 Dr Aaron Groves, Queensland Health, *Committee Hansard*, 9 August 2011, p. 2. See also Ms Catherine O'Toole, President, State Council, Queensland Alliance for Mental Health, and Chief Executive Officer, Advance Employment, *Committee Hansard*, 9 August 2011, pp. 20-21.

organisation, some health services had indicated that work was not a priority for their clients:

> ... when we first started doing this model we spoke to clinical teams and some of the people said 'We have no idea if our clients work or not. We are a health service; we are not interested in work.'[64]

1.74 Professor Killacky, Director, Psychosocial Research at Orygen Youth Health cited one instance of a case-manager's 'well-intentioned but misdirected care':

> A young woman who out employment consultant was working with wanted to work in retail. Our employment consultant thought she probably was not quite there, but there was a course she could do through VET-the TAFE side of that-that gets people ready to work in retail. It is a small course-there were only around six people in it- and it is very well linked into things, so there is pretty much a guaranteed job at the end of it. We got the client onside with that, as well as her boyfriend and family. Everyone was really supportive. In her case it was said, 'No, it would be too stressful for you.' That course has one opening every six months.[65]

Stigma in families

1.75 The concerns of well-intentioned family members that the return to work of their loved one will be stressful and exacerbate mental ill health can also contribute to stigmatisation. Dr Groves of Queensland Health commented that families and carers can find it difficult to comprehend that someone who has been very unwell can get back to work. Dr Groves indicated that family members can try to prevent further work-related stress by creating a:

> ... protective layer of 'If we then encourage them or force them to go to work, we are only going to make them crook again.'[66]

1.76 This protective response was also identified by Ms Christine Bowman, Transforming Perceptions Project Coordinator, Mental Health Community Coalition ACT. Ms Bowman related a case of a mother who wanted to protect her daughter. The daughter had mental ill health and her mother

64 Ms Laura Collister, General Manager, Rehabilitation Services, Mental Illness Fellowship Victoria, *Committee Hansard*, 13 April 2011, p. 4.

65 Professor Eoin Killackey, Director, Psychosocial Research, Orygen Youth Health, *Committee Hansard*, 24 March 2011, p. 3.

66 Dr Aaron Groves, Queensland Health, Committee Hansard, 9 August 2011, p. 7.

had protected her from stigma in the community by keeping her out of mainstream society.[67]

1.77 In culturally and linguistically diverse (CALD) communities, the stigma of mental ill health may be particularly acute and complex. Shame associated with mental ill health and the treatment methods in countries of origin can prevent diagnosis and treatment. Ms Brooke McKail, Executive Officer, Mental Health Community Coalition ACT, explained that CALD communities can consider mental ill health to be a private issue, not one for the broader community. This is because mental ill health can be perceived within the context of:

> cultural or traditional beliefs around the ideas of madness and the shame and humiliation that can come from that. Often people blame themselves for mental illness or see it as a punishment.[68]

1.78 While the Committee heard that some families support was not forthcoming or perhaps misguided, the Committee does acknowledge the many supportive parents and carers it met throughout the course of the inquiry, clearly doing their utmost to help their loved one into employment.

1.79 Professor Killackey made the very important point that:

> While work can be stressful, being unemployed is pretty stressful too-probably more so – so there needs to be some education with families around those two different stresses.[69]

Self-stigma

1.80 People with mental ill health may internalise the stigma that is circulating throughout the community and workplace that can be reinforced by families and clinicians, forming a negative perception of themselves, with associated low expectations. This is called self-stigma. Mr Keith Mahar, Ambassador, Disability Employment Australia, reported that self stigma had brought him close to suicide.[70]

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67 Ms Christine Bowman, Transforming Perceptions Project Coordinator, Mental Health Community Coalition ACT, *Committee Hansard*, 13 May 2011, p. 13.

68 Ms Brooke McKail, Executive Officer, Mental Health Community Coalition ACT, *Committee Hansard*, 13 May 2011, p. 8.

69 Professor Killackey, Director, Psychosocial Research, Orygen Youth Health, Committee Hansard, 13 April 2011, p.20.

70 Mr Keith Mahar, Ambassador, Disability Employment Australia, *Committee Hansard*, 13 October 2011, pp. 8-9.

1.81 Ms Lisa Thiele, Sessional Education Worker, Mental Illness Fellowship of South Australia, stated that she too experienced self-stigma. Ms Thiele said that she did not feel comfortable talking about her health issues because she had internalised the social stigma of mental ill health:

> I felt I could not share my past with anybody because it was just far too embarrassing.[71]

1.82 Self-stigmatisation is perhaps the most debilitating manifestation of stigma associated with mental ill health. When limits are self-imposed it can be exceptionally difficult to rebuild people's self-esteem and self-confidence.

1.83 One respondent to the Australian Youth Forum (AYF) consultation on mental health and workforce participation said:

> A lot of times the only obstacle to success is ourselves...after having a mental illness you need to overcome the fear and pity and reject the stereotype of your illness yourself to move on and be all you can be![72]

Disclosure

1.84 'Disclosure' refers to the decision of an individual to inform others of conditions associated with their mental ill health. Disclosure of mental ill health relies on individuals being diagnosed, identifying that they have mental ill health, and then being comfortable sharing that information.[73]

1.85 A recent National Centre for Vocational Education Research report, *Unfinished business: student perspectives on disclosure of mental illness and success in VET* (the NCVER report) referred to students' reasons for not disclosing their illness:

> Students usually do not disclose their illness at the outset for the following reasons: they want to be self-reliant and to protect their sense of self as a coping person; they fear stigma, prejudice and rejection; and they don't consider an episode of psychosis or depression as a 'disability'[74]

71 Ms Lisa Thiele, Sessional Education Worker, Mental Illness Fellowship of South Australia, *Committee Hansard*, 7 June 2011, p. 11.

72 Australian Youth Forum, *Submission 73,* p. 12.

73 Mr John Dalgleish, Manager, Strategy and Research, BoysTown, *Committee Hansard*, 9 August 2011, p. 34.

74 DEEWR, NCVER Research Report, *Unfinished business: student perspectives on disclosure of mental illness and success in VET*, Annie Venville and Annette Street, La Trobe University, Melbourne, 2012, p. 8.

1.86 Every interaction is considered a high risk event. Therefore, disclosure is a complex, personal decision, and witnesses insisted the decision to disclose must be made by the individual.[75] Cases of nondisclosure remain 'very high' due to associated and perceived stigma among associates and colleagues.[76] Self-stigma is another factor.

1.87 Many witnesses reported negative experiences of disclosure. A former client of Orygen Youth Health commented that when she disclosed her mental ill health in job applications she had received 'quite significantly less' interview opportunities than when she did not disclose.[77] Similarly, Ms Sarah Reece, a participant in the PHaMS West program relayed her negative experiences of disclosing at university:

> ... when I screwed up my courage and disclosed to the counsellor whom I had been seeing there a few times the nature of my mental illness, she told me I was not to come back to the service and closed the entire counselling support service to me at the university, which devastated me and left me without any support on site and I withdrew. In fact, I failed at each of my attempts to re-engage [with] university.[78]

1.88 Ms Bernette Redwood, Executive Officer, Vista Vocational Services, reported an instance where disclosure provoked negative perceptions, such as when she spoke to a human resources manager at the Australian Taxation Office about her organisation:

> He sat there with his arms folded looking extremely uninterested. At the end of my spiel he said 'Bernette, the trouble is you can always tell a person with a mental illness'. I said 'You know, that is really interesting because I have one'. And I thought the man was going to run out of the room. That is the attitude of HR managers in government situations. And I think, although it might not often be stated, it is often what is felt.[79]

1.89 Whilst disclosing mental ill health can present a significant cost for individuals, by not doing so they may miss receiving support that could

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75 For instance, Mr Nicholas Bolto, Chief Executive Officer, Ostara Australia, *Committee Hansard*, 13 April 2011, p. 35; Mr Andrew Mitchell, Director of Mental Health, Employment and Counselling, Wesley Mission, *Committee Hansard*, 17 June 2011, p. 25.

76 Mr Nicholas Bolto, Chief Executive Officer, Ostara Australia, *Committee Hansard*, 13 April 2011, p. 35.

77 Miss A, Former client of Orygen Youth Health, *Committee Hansard*, 13 April 2011, p. 13.

78 Ms Sarah Reece, Participant, PHaMs West Program, *Committee Hansard*, 7 June 2011, p. 3.

79 Ms Bernette Redwood, Executive Officer, Vista Vocational Services, *Committee Hansard*, 13 May 2011, p. 15.

be available to help them. Nondisclosure can also exacerbate anxiety. Ms Reece commented that choosing to not disclose is difficult:

> ... not telling them leaves me really scared that they might find out, which means that if you are doing something like accessing support at a place like the Mental Illness Fellowship you are always worried that someone might see you someone going in that door. It is very difficult. It also leaves you without any sort of support if things do get a bit rocky.[80]

1.90 Interestingly, the NCVER report showed that while students struggled to decide whether to disclose or not, most staff members expected students to disclose if they had an illness, perceiving it to be part of taking responsibility for their own education.[81]

1.91 Ms Laura Collister, General Manager, Rehabilitation Services, Mental Illness Fellowship Victoria said that they encourage disclosure because they think that encourages a very open relationship with employers. She emphasised that disclosure is 'not an all or nothing thing':

> How much you disclose is an individual thing. It may be that somebody says they have a health issue that at times is going to cause this and this to happen. How are we going to manage it? Versus, 'I have this diagnosis'. It is not an all or nothing thing and it changes over time.[82]

Promoting mental health awareness

1.92 Throughout the inquiry process, the Committee met a broad cross-section of people with mental illness, those battling mild, moderate and severe forms, young, middle-aged and older Australians, some less skilled and some with very high levels of skills and professional qualifications. According to the statistics set out at the beginning of this chapter, anywhere from one in five people to one in three people are affected. Clearly, we are all affected, if only by someone we know.

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80 Ms Sarah Reece, Participant, PHaMs West Program, *Committee Hansard*, 7 June 2011, p. 5.

81 DEEWR, NCVER Research Report, *Unfinished business: student perspectives on disclosure of mental illness and success in VET*, Annie Venville and Annette Street, La Trobe University, Melbourne, 2012, p.3.

82 Ms Laura Collister, General Manager, Rehabilitation Services, Mental Illness Fellowship Victoria, *Committee Hansard*, 13 April 2011, p. 7.

1.93 The Committee hopes that this report will play a part in dispelling some of the myths about mental illness and people with a mental illness in the workforce. To this end, it is necessary to relate the stories of people with mental health conditions who want to work and are already doing so successfully, across a spectrum of fields. The desire to participate persists, in some cases despite well-intentioned family members, clinicians or case-managers not believing that this is possible or beneficial because it is too 'stressful'.

1.94 To kick-start discussions and set the tone, the inquiry topic was highlighted in the May 2011 *About the House* television program. In the segment titled, 'Helping the mentally ill find work' Chris Tanti, the Chief Executive Officer of Headspace, spoke about how critical getting young people with mental health issues into employment or education is for their wellbeing. The importance of an understanding boss, effective two-way communication between employee and employer and other appropriate supports in the workplace were also underlined. Professor Peter Butterworth, a researcher from the Australian National University underscored the importance of a positive work environment and high quality job for mental health and wellbeing as well.

1.95 The August 2011 edition of the *About the House* magazine also ran a feature story about the inquiry on the most pervasive barrier for job seekers – namely stigma. It appears that fear and misunderstanding about mental illness are the foremost barriers to participation.

1.96 One of the witnesses that appeared at the Committee's first Canberra hearing, Vista Vocational Services Executive Officer, Bernette Redwood, was interviewed together with people helped through the two businesses she runs that specifically employ people with a mental illness. Vista provides trainees with practical training in hospitality or horticulture and helps transition them into mainstream employment.

1.97 The piece shows that great achievements are possible for even the most disadvantaged individuals. A degree of understanding, support and being 'given a go' can have wonderful results. One trainee related his experience:

> I've just been sitting on the lounge for about six to eight years and it's really got me out of my comfort zone and into work..."I've stuck with it, got fitter and more energy and it's really helped me a lot.[83]

83 Mr Michael Dickenson, trainee, North South Contractors, in Jeremy Kennet, 'Safe choice', *About the House,* August 2011, pp.26-30.

1.98 It is evident that engaging in purposeful education, training and employment contributes markedly to recovery.

1.99 This report serves to showcase the diversity, strength and resilience of people with mental ill health and what the community has to gain by their inclusion in the workforce.

Promoting mental health in the workplace

1.100 A strong theme in evidence to the inquiry was the critical importance of actively promoting mental health and wellbeing in workplaces for all employees.

1.101 Recent Medibank[84] research into workplace health, *Economic modelling of the cost of presenteeism[85] in Australia: 2011 Update* found that mental ill-health accounts for 21 per cent of presenteeism, making it the greatest single driver of the phenomenon. Medibank stated:

> With the total cost of presenteeism estimated at $34.1 billion in 2009-2010, there is a clear incentive for business and government to work together to address mental health in the workplace.[86]

1.102 A number of submissions to the inquiry, including those from the Black Dog Institute and Beyond Blue emphasised the importance of early intervention with employees who may be exhibiting symptoms of mental ill health. And, more broadly, promoting the mental health and resilience of all employees, irrespective of whether or not they are known to suffer from a mental illness.[87]

1.103 To this end, sound human resource practices that seek to build mental health and well-being awareness, amongst managers and employees are integral. These practices include disseminating information on how to obtain help and support for individuals when they need it, as well as strategies to promote resilience in the workforce as a whole.

1.104 The responsibility does not rest solely within human resources departments either. Leadership and organisational buy-in on the issue is critical to success. Mainstreaming the issue from the top down ('normalising it') plays an important role in breaking down the associated stigma.

84 Medibank is Australia's largest integrated private health insurance and health services group

85 Presenteeism is defined as the lost productivity that occurs when employees come to work but are not fully productive.

86 Medibank, *Submission 63*, p. 4.

87 See Black Dog Institute, *Submission 16*, p. 2 and Beyond Blue, *Submission 21.*

1.105 Having a flexible supportive workplace culture where the channels of communication are open is one of the most important messages to come out of this inquiry. This modus operandi does not just apply to accommodating workers with a mental illness.

National and international stigma reduction campaigns – in schools, workplaces and the broader community

1.106 One of the strongest calls from witnesses, including state governments, is for a broad anti-stigma reduction community education campaign, to be supported by the Commonwealth Government. The views of Canefields Clubhouse were typical when it asserted:

> The introduction of a national reduction of stigma campaign is long overdue and would provide improved understanding of, and attitudes towards, mental illness by the community at large, employers and educators.[88]

1.107 Mental Illness Fellowship of Victoria called for an anti-stigma campaign specifically directed at the workplace:

> There is need for a national workplace focussed anti-stigma and engagement campaign that encourages employers to 'give people with a mental illness a go' in the workplace. [89]

1.108 Neither suggestion is new. The Senate Select Committee on Mental Health's report of 2006 recommended that the Commonwealth Government fund and implement a nationwide mass media mental illness stigma reduction and education campaign.[90]

1.109 The Queensland Alliance for Mental Health referenced the Australian Government (DEEWR) 2009 report, *Employer Attitudes to Employing People with a Mental Illness*, which stated that research suggests that various interventions be supported by:

> a wider campaign aimed at addressing community prejudice against people with a mental illness. The majority of participants believed that without such a campaign the usefulness and

88 Canefields Clubhouse Beenleigh, *Submission 5*, p.2

89 Mental Illness Fellowship of Victoria, *Submission 57*, p. 4.

90 Senate Select Committee on Mental Health report, 'A national approach to mental health – from crisis to community', April 2006, p. 15.

> effectiveness of resources targeted towards employers could be compromised.[91]

1.110 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, explained that in the mid- 1990s an anti-stigma campaign was run by the Commonwealth Government which started to increase people's awareness of mental illness. Since then governments had been investing in organisations like Beyondblue to educate the Australian community on depression, although that does not yet extend to more serious illness like bipolar disorders and schizophrenia. He added, that in 2009, health ministers agreed to develop a national stigma reduction strategy. However, this has not progressed very far. He said:

> It is still in its early stages. It is fair to say that we are not having a lot of runs on the board in developing a stigma reduction strategy that cuts across the whole of mental illness.[92]

1.111 The states are revisiting this issue. The Mental Health Council of Tasmania (MHCT) indicated that it is working with the Tasmanian Government to develop a social marketing campaign to redress stigma and discrimination in Tasmania.[93]

1.112 Dr Groves indicated that the Queensland Government had committed to a stigma reduction strategy in its 2010 Budget to focus on the more 'severe end of the spectrum' of mental illnesses. He elaborated on the Queensland Government's approach, which has a focus on schools and workplaces:

> We believe there are a couple of forums that are particularly good at tackling this. One of them is schools because you tend to have all the schoolchildren there. It is a nice captive audience to start to talk to them and demystify some of the issues around mental illness. The other place is the workplace. Again, most adults do go to work. We find that attitudes towards people with mental illness are incredibly stigmatising despite the fact that every worker in Australia is likely to have someone with a mental illness in their workplace...We think that it is really important to tackle that in the workplace; one to get a better understanding; and two,

91 DEEWR, 'Employer attitudes to employing people with a mental illness', September 2008, p.3 referred to in Queensland Alliance for Mental Health, Submission 36, p.9.

92 Dr Groves, Queensland Health, *Committee Hansard*, 9 August 2011, p. 5.

93 Tasmanian Government, *Submission 50*, p. 15.

> so that people can see that work colleagues with mental illness who are on their recovery are valued workers.[94]

1.113 Dr Groves described the Queensland Government strategy as being 'not just a social marketing campaign', that is television advertisements explaining what mental illness is, but rather a more nuanced and interactive experience:

> A grassroots activity where community groups and people in communities can get exposed to people who have a lived experience of mental illness and talk to them about the sorts of issues they have and how they are living within their communities.[95]

1.114 Mr Adam Stevenson, General Manager, Queensland Department of Employment, Economic Development and Innovation reinforced the notion that education campaigns should go beyond mere 'awareness raising'; they must engage their target audience:

> These are constant interactions that government needs to have with employers at various points...it is certainly something that is constant work.[96]

1.115 The Mental Illness Fellowship of South Australia (MIFSA) echoed how important it is for governments to play a role in raising awareness. MIFSA observed that so doing 'is very much about normalising the idea' of people experiencing mental ill health and promoting resilience amongst the workforce as a whole:

> It is that encouragement and awareness from government to say that one in five are going to have an issue with this...about normalising it: raising awareness, reducing stigma and building that resilience amongst staff and providing opportunities for the people who experience mental illness to have that conversation with their employers.[97]

1.116 Representatives of the South Australian Health Service similarly espoused the benefits of a strong public education campaign as an effective way to influence people's views. Mr John Strachan, Acting Outer South Sector

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94 Dr Aaron Groves, Queensland Health, *Committee Hansard*, 9 August 2011, p. 5.

95 Dr Aaron Groves, Queensland Health, *Committee Hansard*, 9 August 2011, p.5.

96 Mr Adam Stevenson, General Manager, Queensland Department of Employment, Economic Development and Innovation, *Committee Hansard*, 9 August 2011, p. 6.

97 Mr Deiniol Griffith, Team Leader, Peer Work Project, MIFSA, *Committee Hansard*, 7 June 2011, p. 13.

Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, said:

> [it] starts to really showcase to the public and everyone involved that there are greater alternatives than what they might have thought.[98]

1.117 The Queensland Government called for a national approach to educate workers and employers alike, :

> To develop a targeted campaign, in consultation with states and territories, to educate all Australians on mental illness in the workplace, and to educate employers and workers on how to obtain support for people experiencing mental illness at work.[99]

1.118 The Mental Health Council of Tasmania referenced other countries' national campaigns, including New Zealand's 'Like Minds-Like Mine', Scotland's 'See Me 'and the United Kingdom's 'Time to Change' as potential models for an Australian stigma reduction campaign .[100] Of the three, the Scottish and UK campaigns are perhaps most instructive in terms of their engagement with workplaces.

1.119 The more community focused 'Like Mind-Like Mine' campaign from New Zealand received praised from several witnesses. The Royal Australia and New Zealand College of Psychiatrists said:

> The successful New Zealand 'Like Minds, Like Mine' campaign has used a combination of well-known personalities and everyday people to remove the social taboo associated with mental illness. Individuals talk on camera about their illness, discussing the support they receive from their employer, friends and family, [and they in turn] discuss how their understanding of mental illness has grown.[101]

1.120 The Welfare Rights Centre described 'Like Minds Like Mine' as a ground breaking program.[102] Mr Bailey of Macquarie University noted New Zealand's very good media programs:

> with well-known figures, usually rugby players, talking about mental illness...de-stigmatising it and normalising it.[103]

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98 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, p. 29.

99 Queensland Government, *Submission 56*, p. 7.

100 Mental Health Council of Tasmania, *Submission 18*, p.1.

101 The Royal Australian and New Zealand College of Psychiatrists, *Submission 39*, p. 6.

102 Welfare Rights Centre, *Submission 10*, p. 9.

103 Mr Bailey, private capacity, *Committee Hansard*, 17 June 2011, p. 19.

1.121 Operating since 1997, and the longest-running of the three overseas programs, 'Like Minds Like Mine' is funded by the New Zealand Ministry of Health and run by a number of national contractors (including Lifeline and the Mental Health Foundation) and regional providers, with national coverage. The national contractors are responsible for providing national services like television advertising campaigns, a free information telephone service and website. To complement these activities, regional providers undertake anti-discrimination activities with local community groups and organisations, maraes, business and media.[104]

1.122 Launched in 2002, 'See Me Scotland' describes itself as the sister campaign to that of 'Like Mind Like Mine' and is an alliance of five mental health organisations funded by the Scottish government to end the stigma and discrimination of mental ill-health there. A variety of resources are available on a website, such as case studies of organisations that have successfully worked with 'See Me', and encourages signing a pledge and accompanying action plan to make a public commitment because:

> Such a commitment will be seen by employees, by customers or users of services and the wider public.[105]

1.123 The Steps to Success section offers practical suggestions for raising awareness in the workplace of mental illness and appropriate supports to employees, for example:

- **Raising awareness –** through putting up leaflets and posters and getting involved in Scottish Healthy Working Lives (whose principle focus is to work with employers to enable them to understand, protect and improve the health of their employees and contribute to the Scottish Government's national outcomes);
- **Support –** encourage your organisation to use internal or external support for employees for example Employee Counselling Service;
- **Education -** the Mentally Healthy Workplaces Training provides necessary information for employers while Mental Health First Aid is suitable for all staff;
- **Check it out –** Work Positive is a stress risk management resource, developed to support employers to identify and reduce the potential causes of stress in the workplace.[106]

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104 See Like Minds Like Mine website for details: http://www.likeminds.org.nz/page/33-like-minds-national-structure and http://www.likeminds.org.nz/page/24-about-like-minds-like-mine

105 See Me website, http://www.seemescotland.org/getinvolved/asanorganisation/signtheseemepledge

1.124 Describing itself as England's biggest ever attempt to end the stigma and discrimination experienced by people with mental health problems, the UK's Time to Change -let's end mental health discrimination campaign was established in 2007. Funded by the UK Department of Health and the charitable organisation Comic Relief, it is run by the mental health charities Mind and Rethink Mental Illness, and described as 'a campaign to change attitudes, and behaviour.' Not dissimilar to 'See Me', the campaign aims to:

> Start a conversation... we want to empower people to feel confident talking about the issue without facing discrimination...and the three quarters of the population who know someone with a mental health problem to talk about it too.[107]

1.125 The United Kingdom campaign is multifaceted and comprises:

- a national high profile marketing and media campaign aimed at adults;
- community activity and events that bring people with and without mental health problems together;
- work with children and young people;
- supporting a network of people with lived experience of mental health problems to take leadership roles in challenging discrimination, within their own communities;
- getting workplaces involved in Time to Change;
- media engagement to improve media reporting and representations of mental health issues; and
- focused work with minority and ethnic communities.[108]

1.126 The website offers a comprehensive and impressive array of resources, including short video clips of well-known public figures (ranging from a boxer to political aide and television personalities) interspersed with 'ordinary people' relaying their various experiences of a lived experience of mental illness. There are sections titled 'support for workplaces' (aimed at employees and co-workers) and 'support for employers' respectively. Like the 'See Me' campaign there are successful case-studies on the website and organisations are encouraged to make an organisational pledge.[109]

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106 See Me website, http://www.seemescotland.org/getinvolved/asanorganisation/steps-to-success

107 Time to Change website, http://www.time-to-change.org.uk/node/31071

108 Time to Change website, http://www.time-to-change.org.uk/node/31071

109 Time to Change website, http://www.time-to-change.org.uk/your-organisation/organisational-pledge

1.127 'Time to Change' reports that it is now working with hundreds of organisations across the United Kingdom.[110]

1.128 Ms Sue Baker, Director of 'Time to Change' cites an evaluative study from the Institute of Psychiatry at King's College, London that concluded that there has been a nine per cent drop in discrimination experienced by those looking for a job since the campaign commenced. [111]

1.129 Chapter three refers to Beyondblue, Sane and other workplace education campaigns and tools like mental health first aid, which receive some support from the Commonwealth Government. Beyond blue is supported by the Commonwealth Government and all state and territory governments.[112] The NSW Government funds the Black Dog Institute in NSW.[113]A number of witnesses attest to these programs making a difference in workplaces and the wider community.

1.130 Black Dog Institute referred to the successes of large awareness campaigns like Beyondblue's demystifying depression campaigns.[114] Professor Helen Christenson, President of the International Society for Research on Internet Interventions applauded the efforts of Beyondblue and others for their online presence and success in awareness raising and improving mental health literacy.[115] The Royal Australian and New Zealand College of Psychiatrists noted that specific campaigns raise awareness and expectation of treatment.[116]

1.131 The Committee recognises that there are already a number of stand-alone government-funded programs that operate in or around this space.

1.132 Besides Beyondblue and Blackdog, there is also KidsMatter, the education and awareness raising tool for children in schools on mental health mentioned in chapter two, and Comcare's anti-bullying campaign targeting workplaces, 'Work Safety Campaign – Don't be a silent witness'[117], designed to be a tool for improving the psychological health of employees in workplaces.

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110 Time to Change website, http://www.time-to-change.org.uk/your-organisation

111 Time to Change website, video clip, http://www.time-to-change.org.uk/about

112 Beyond Blue website, 'Funding Structure', http://www.beyondblue.org.au/index.aspx?link_id=2.23

113 Black Dog Institute website, 'Funding', http://www.blackdoginstitute.org.au/aboutus/funding.cfm

114 Black Dog Institute, *Submission 16*, p. 1.

115 Professor Helen Christensen,

116 Royal Australian and New Zealand College of Psychiatrists, *Submission 39*, p. 6.

117 Comcare, *Submission 64*, p. 4.

1.133 Governments in Australia have themselves recognised the need for a national stigma reduction strategy, through the COAG process and development of the Fourth National Mental Health Plan. Priority area 1: Social Inclusion and Recovery has as its first outcome, and corresponding actions:

> That the community has a better understanding of the importance and role of mental health and recognises the impact of mental illness.
>
> To improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy.
>
> To work with schools, workplaces and communities to deliver programs to improve mental health literacy and enhance resilience.[118]

1.134 Moreover, the National Mental Health Plan recognises that while to-date the focus has been on the more common mental illnesses, namely depression and anxiety, national education and awareness campaigns need to also:

> Include those illnesses that are more complex and difficult to understand such as psychosis.[119]

1.135 Further, the campaign should:

> Work in conjunction with actions addressed to particular groups such as those from culturally and linguistically diverse backgrounds, rural and remote communities and particular age groups.[120]

1.136 The Committee is of the view that the time has come for a much more significant nationally coordinated stigma reduction campaign throughout

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118 Australian Government, Fourth national mental health plan: an agenda for collaborative action 2009-2014, http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-f-plan09-toc~mental-pubs-f-plan09-sum#soc

119 Commonwealth Government, Fourth National Mental Health Plan, Priority Area 1: Social Inclusion and Recovery, p. 27, http://www.health.gov.au/internet/main/publishing.nsf/content/360EB322114EC906CA2576700014A817/$File/pla1.pdf

120 Commonwealth Government, Fourth National Mental Health Plan, Priority Area 1: Social Inclusion and Recovery, p. 27, http://www.health.gov.au/internet/main/publishing.nsf/content/360EB322114EC906CA2576700014A817/$File/pla1.pdf

Australia, not dissimilar to the international models presented to it, that targets workplaces, schools, and also the community at large.

1.137 It is fair to say that there is an increased understanding in the community about common mental illnesses – depression and anxiety (the most common forms of mental illness are depression – suffered by approximately 15 per cent of adults, and anxiety disorders – experienced by approximately 26 per cent of adults)[121], and this is due not least to the advocacy efforts of organisations such as Black Dog and Beyond Blue.

1.138 However, perhaps less well-understood by the community are the more severely disabling 'low prevalence' mental illnesses like bipolar disorder, schizophrenia and other forms of psychosis, which affect about three per cent of the adult population.[122]

1.139 Any national education campaign should redress this education gap. Rather than simply replicating the Beyond Blue and Black Dog models, the national education campaign should complement the work of these organisations, and include a focus on demystifying the more complex and less well-understood forms of mental illness.

121 Source: Better Health Channel, Victorian Government website, *Mental illness prevalence*, http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Mental_illness_prevalence

122 Better Health Channel, Victorian Government website, *Mental illness prevalence*, http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Mental_illness_prevalence

Recommendation 1

The Committee recommends that the Commonwealth Government coordinate a comprehensive and multi-faceted national education campaign to target stigma and reduce discrimination against people with a mental illness in Australian schools, workplaces and communities. The campaign should:

- **include involvement from the public, private and community sectors, educational institutions, employers and a range of other stakeholders, including individuals with mental illnesses, families and carers; and**
- **complement existing government-funded education and awareness campaigns on depression and mood disorders, with an inclusion of psychotic illnesses.**

Scope of inquiry and parameters

What is mental ill health?

Definitions

1.140 There is a fundamental distinction to be made between a mental illness and intellectual disability or brain damage. When mental illness is considered a disability, as it tends to be in policy terms (where it is usually subsumed into the disability category), there is a risk of lumping those with a mental or intellectual impairment together with those with a mental illness. Someone may have mental illness such as depression or anxiety as a result or side effect of brain damage but the terms are not interchangeable.

1.141 Because mental illness is episodic in nature, it is quite different from a permanent physical or mental disability. Someone with a mental illness may, in fact, be well most of the time.

1.142 Someone with mental ill health might therefore 'slip through the cracks' of services provision if, for example, they are registered with Job Services Australia rather than disability employment services, or they are in the disability management service rather than employment support service

stream of a disability employment services provider which offers more ongoing support.

1.143 The statistics indicate that although mental illness and mental health problems are experienced by many Australians, it is still not a subject that most people appear especially comfortable with or knowledgeable about.

1.144 Some basic definitions and facts are provided in this introductory chapter, for the sake of clarity and to frame the discussions in the remaining chapters.

1.145 DoHA offers the following definitions:

> A **mental illness** is a health problem that significantly affects how a person feels, thinks, behaves, and interacts with other people. It is diagnosed according to standardised criteria. The term **mental disorder** is also used to refer to these health problems.
>
> A **mental health problem** also interferes with how a person thinks, feels, and behaves, but to a lesser extent than a mental illness.
>
> Mental health problems are more common and include the mental ill health that can be experienced temporarily as a reaction to the stresses of life.
>
> Mental health problems are less severe than mental illnesses, but may develop into a mental illness if they are not effectively dealt with.[123]

1.146 The Victorian Government Health website categorises mental illness into two groups:

> **Depression and anxiety disorders –** for example, persistent feelings of depression, sadness, tension or fear that are so disturbing they affect the person's ability to cope with day-to-day activities. Conditions that can cause these feelings include: anxiety disorders (for example, phobias and obsessive compulsive disorder), eating disorders and depression.
>
> **Psychotic illness –** for example, schizophrenia and bipolar disorder (previously called manic depressive illness). Psychosis

123 Department of Health and Ageing website, 'What is mental illness'?, http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-w-whatmen-toc~mental-pubs-w-whatmen-what

> affects the brain and causes changes in a person's thinking, emotions and behaviour. People who experience an acute psychotic episode lose contact with reality and may develop delusions or hallucinations.[124]

1.147 As mentioned in the previous section, the more common forms of mental illness fall into the first category, namely depression and anxiety disorders. The less common ones fall into the psychotic illness category.

1.148 Sane Australia, the national charity working for a better life for people affected by a mental illness, has produced a website that contains a range of materials that people can access and download that explain the symptoms, causes and treatments available for a spectrum of mental illnesses –including the less common and less well-understood ones- in easy to understand formats. This takes the form of factsheets, downloadable podcasts and other multimedia materials.[125]

1.149 For example, the website sets out plain English descriptions of schizophrenia - a medical condition that interferes with a person's ability to think, act and feel, and counters the commonly held misperception that 'those affected have a "split personality"'.[126]

1.150 Finally, while definitions are helpful for improved awareness and understanding within the community, people with a mental illness do not wish to be defined by their condition:

> It is not beneficial to label people with a mental illness (e.g. schizophrenic) as this then becomes their identity.[127]

1.151 Even using the phrase mental illness can have negative connotations and:

> Reinforce misleading assumptions about the unsuitability of people with mental health conditions as employees.[128]

1.152 Dr Geoffrey Waghorn RM, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research spoke about the importance of language and the various ways to construct a more positive narrative about an employee with a mental illness:

> From research we know that the word schizophrenia triggers unfair discrimination but the phrase 'late starter' does not...we

124 Better Health Channel, Victorian Government website, *Mental illness prevalence*, http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Mental_illness_prevalence

125 Sane Australia website, http://www.sane.org/information/factsheets-podcasts

126 Sane Australia website, http://www.sane.org/information/factsheets-podcasts

127 Name withheld, *Submission 12*, p. 1.

128 Queensland Alliance for Mental Health, *Submission 36*, p.9.

> have to translate those mental health diagnostic terms into behaviours in the workplace that employers understand...we know how to do it...what [employment services] have to do is to develop a plan with their clients to manage their personal information so they identify the adverse information they do not want to talk about and give the client a choice about what terms they would prefer to use to describe their situation..in order to emphasise their strengths...you have to develop a very balanced, accurate story that does not use medical terminology typically...Once the employer gets to know the person, research quite clearly shows that diagnostic terminology is less likely to cause unfair discrimination, because the employer will say, 'my worker has schizophrenia but they do not have multiple personalities. ..They will see past the stigma that that conjures up.[129]

1.153 Not dissimilarly, Professor Eoin Killackey, Director, Psychosocial Research, Orygen Youth Health, talked about how many young people, and others too, with mental health issues do not necessarily self-identify or perceive themselves as having a disability, therefore may not even register that disability employment services assistance is targeted at them. He went on to say that is a good thing:

> That lack of perception of a disability, particularly for young people, is a good thing and we can leverage that to actually help people.[130]

1.154 The report uses the terms persons with a mental illness, mental ill-health and mental health condition interchangeably for no reason other than they all appear to be used by and cover the range of mental health problems from mild symptoms through to more severe mental disorders.

1.155 The Committee appreciates that categorising someone with a mental illness as having a disability can be problematic however the report will continue to do so given that the Government frames services for them in this way.

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129 Dr Geoffrey Waghorn, RM, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, *Committee Hansard*, 9 August 2011, pp. 14-15.

130 Professor Eoin Killackey, Director, Psychosocial Research, Orygen Youth Health, *Committee Hansard,* 24 March 2011, p. 4.

People with mental ill health can and do recover – the facts

1.156 Just as the types of specific mental illnesses are not universally understood, it is not necessarily common knowledge that, with the appropriate treatment and support, the majority of people with mental illness can be treated, manage their illness and recover.

1.157 To reiterate, a mental illness is differentiated from a permanent physical or mental disability as it is characterised by episodic presentation which means it occurs irregularly, occasionally or sporadically.

1.158 The DoHA website explains:

> Episodes of mental illness can come and go during different periods in people's lives. Some people experience only one episode of illness and fully recover. For others, it recurs throughout their lives.
>
> Most mental illnesses can be effectively treated. Recognising the early signs and symptoms of mental illness and accessing effective treatment early is important. The earlier treatment starts, the better the outcome.
>
> Effective treatments can include medication, cognitive and behavioural psychological therapies, psycho-social support, psychiatric disability rehabilitation, avoidance of risk factors such as harmful alcohol and other drug use, and learning self-management skills.
>
> It is rarely possible for someone with a mental illness to make the symptoms go away just by strength of will. To suggest this is not helpful in any way.
>
> People with a mental illness need the same understanding and support given to people with a physical illness. A mental illness is no different – it is not an illness for which anyone should be blamed.[131]

1.159 The Victorian Government website offers some statistics on the rates of successful recovery for different mental illnesses:

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131 Department of Health and Ageing website, 'What is mental illness', http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-w-whatmen-toc~mental-pubs-w-whatmen-what

- **Anxiety disorders** – the majority of people will improve over time.
- **Bipolar disorder** – about 80 per cent of people will improve.
- **Schizophrenia** – about 60 per cent of people with schizophrenia will improve and can live independently with support. About 20 per cent of those diagnosed with schizophrenia will have an episode or two, and then never experience symptoms again. For another 20 per cent, symptoms are more persistent, treatments are less effective and greater support services are needed.[132]

Conduct of inquiry

Referral of inquiry

1.160 The Minister for Tertiary Education, Skills, Jobs and Workplace Relations, Senator the Hon. Christopher Evans referred the inquiry to the Committee on 28 February 2011.

1.161 The terms of reference for the inquiry are set out in the front pages of the report.

The inquiry process

1.162 The Committee announced the inquiry at a press conference held at Parliament House on 3 March 2011 and called for submissions from interested individuals and organisations.

1.163 The inquiry was advertised in *The Australian* newspaper on an on-going basis and also on the Committee website.

1.164 The Committee also invited submissions directly from a wide range of stakeholders. These included federal, state and territory ministers, peak and advocacy bodies, employers, disability employment services providers, research institutions, and community organisations.

1.165 A total of 76 submissions were received from a broad cross-section of individuals and organisations with an interest in the subject matter, from people with a lived experience of mental ill health, either themselves or as a carer, support groups and social services providers, health professionals,

132 Department of Health and Ageing website, 'What is mental illness', http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-w-whatmen-toc~mental-pubs-w-whatmen-what

policy makers, academics, and educational institutions. The submissions are listed in Appendix A.

1.166 Appendix B details the 42 exhibits accepted as evidence.

1.167 The Committee conducted 16 public hearings as well as 16 site inspections in all state and territory capitals, and a sample of outer metropolitan and regional areas in Victoria, South Australia and New South Wales. A private briefing from Orygen Youth Health was subsequently authorised as public evidence to the inquiry. Details of hearings and witnesses are included at Appendix C. Appendix D outlines site visits that the Committee undertook.

1.168 Media releases about the inquiry, submissions received, details of public hearings and transcripts from the hearings are available from the Committee's website.[133]

1.169 In September 2011, the Committee Chair and Deputy Chair met with the Chair and Deputy Chair of the Victorian Parliament's Family and Community Affairs Committee in Canberra and had the opportunity to discuss their respective inquiries into mental health and workforce participation. The Victorian parliamentary inquiry has very similar terms of reference, but with a state focus. The chairs and deputies discussed federal and state perspectives and agreed to complement, rather than repeat, each other's work. The Victorian Committee is due to report in September 2012 and the Committee hopes that this report may contribute to the deliberations of state colleagues.[134]

Commonwealth departments

1.170 Several Commonwealth agencies participated in the inquiry through written submission and attendance at public hearings. The primary written contribution was through a joint submission from DEEWR, DoHA and FaHCSIA. Other agencies to make submissions to the inquiry included, the Department of Human Services (DHS) and Comcare. Representatives from each of these agencies as well as the Commonwealth Ombudsman's Office and the Department of Defence participated in a public hearing.

133 House of Representatives Standing Committee on Education and Employment Committee website, http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=ee/mentalhealth/index.htm

134 For more see Victorian Parliament website, Family and Community Development Committee, http://www.parliament.vic.gov.au/fcdc

1.171 The joint submission provided information regarding the range of programs and initiatives that the Commonwealth supports and administers to help people with mental ill health into education, training and employment.

1.172 The Committee acknowledges that a joint submission is subject to clearances through the procedures of multiple agencies. However, the submission was not received until 21 September 2011, five months after submissions closed and over half way through the Committee's evidence gathering program.

1.173 The lateness of the receipt of the submission hampered the Committee's inquiry because members had only a limited opportunity to explore the effectiveness of Commonwealth support with stakeholders in light of the Commonwealth's responses to the terms of reference.

1.174 Staff from DEEWR, which took the lead role in co-ordinating the joint submission kept the secretariat appraised of its progress. This does not appear to be a case of departments not co-operating with a parliamentary committee but rather the prevention of timely delivery through unwieldy sign off processes.

1.175 Not dissimilarly, answers to questions taken on notice at the hearing held on 14 October 2011 by DEEWR were received three months later by the Committee on 13 January 2012.

1.176 Additionally, at a hearing on 14 October 2011, the Committee requested that the Commonwealth Ombudsman provide updates on responses from Centrelink and DEEWR to its *Falling through the cracks* report.[135] The Ombudsman provided the Centrelink response to this request on 20 December 2011.[136]

1.177 In that correspondence (Submission 74), the Ombudsman indicated that DEEWR had requested that the Ombudsman 'not provide the Committee with a copy of its July 2011 update to the Ombudsman regarding the recommendations made in the *Falling through the cracks* report'.[137] DEEWR proposed instead that a response would later be made available to the Committee containing more recent data that was under preparation to a question on notice from Senator Wright. Following a letter to DEEWR requesting that this information be made available to it without further delay, the Committee received a summary of DEEWR's progress towards

135 *Committee Hansard*, 14 October 2011, p. 34.

136 Commonwealth Ombudsman, *Submission 74*, Attachment A.

137 Commonwealth Ombudsman, *Submission 74,* p. 1. *Committee Hansard*, 14 October 2011, p. 34.

implementing the recommendations of the *Falling through the Cracks* report on 1 March 2012.

1.178 **The Committee endorses a recommendation of the House Standing Committee on Education and Training in the 42nd Parliament to the effect that information requested from Commonwealth departments by parliamentary committees should be provided in a timely fashion.**[138]

Structure of the report

1.179 Following this introductory chapter, the report is structured as follows.

1.180 Chapter two explores some of the barriers to participation in education and training and a range of ways to overcome these, with a focus on high schools, universities and vocational education providers.

1.181 Chapter Three focuses on what employers and workplaces are doing and might do better in this space.

1.182 Chapter Four examines how governments and other service providers endeavour to overcome the different barriers faced by those with mental ill health seeking to enter into or remain in education and training and employment.

1.183 The Committee offers some concluding remarks in Chapter Five.

1.184 It is worth stating at the outset that while the Committee received evidence about the many barriers that present – and these are certainly referred to throughout the report – it does not intend to summarise or reference them all in exhaustive detail. The focus of chapters two, three and four is more solution oriented. All the evidence on barriers is, of course, on the inquiry record.

138 House of Representatives Standing Committee on Education and Training, *Review of the Department of Education, Science and Training Annual Report 2006-07*, May 2009, Recommendation 1.

2

Education and training

> In the general community, finishing high school is one of the key predictors of vocational success, and it is no different for people with a mental illness.
>
> Education is obviously the key to careers rather than just jobs which get you by from time to time.[1]

Youth – onset of mental illness and impact on education

2.1 Headspace, Australia's national youth mental health foundation, stated that '75 per cent of mental health problems occur before the age of 25.'[2]

2.2 According to Headspace, mental health is the number one health issue facing young Australians and contributes to nearly 50 per cent of the burden of disease in this group. Depression and anxiety are the most common manifestations, affecting one in five and one in ten respectively.[3]

2.3 The Australian Psychological Society added:

> The onset of a severe mental illness, which often creates or leads to psychiatric disability, frequently occurs between the ages of 18-25. This is the age when people are making career choices, pursuing higher education or vocational training, and establishing social networks.[4]

2.4 Several other witnesses, amongst them Orygen Youth Health, the Psychosocial Research Centre and the Department of Education,

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1 Associate Professor Eoin Killackey, Director, Psychosocial Research, Orygen Youth Health (OYH), *Committee Hansard*, Melbourne, 13 April 2011, p. 18.

2 Headspace, *Submission 13*, p. 3.

3 Headspace, *Submission 13*, pp. 3-4.

4 Australian Psychological Society, *Submission 40*, p. 13.

Employment and Workplace Relations (DEEWR), emphasised that mental illness commonly strikes people in their youth, derailing the attainment of crucial educational qualifications and subsequent success with further study and work.[5]

2.5 Orygen Youth Health cited a study indicating that only about a third of their clients had obtained a post year-10 education.[6] Orygen expanded on the impact of mental ill health on educational attainment:

> A young person who has experienced psychosis is almost three times less likely to have completed secondary school than their peers and ten to twenty times more likely to be unemployed.[7]

2.6 The Committee received numerous submissions from individuals who provided firsthand accounts of the onset of mental illness in adolescence or young adulthood, at a time when they were in high school or studying at TAFE or university. For many of these individuals, the episodic nature of their illnesses had resulted in an interrupted or incomplete education, commensurate with a loss of self-esteem and motivation.[8]

2.7 The personal stories poignantly illustrate how a lack of adequate support to complete educational qualifications can lead to lower job prospects, if not unemployment and a life on the Disability Support Pension (DSP).

2.8 Professor Killackey of Orygen Youth Health commented that:

> finishing high school is one of the key predictors of vocational success… If [young people with mental illness can get that sort of high school equivalency, there is a great deal of difference between their employment prospects.[9]

2.9 Inspire Foundation was but one of the not-for-profit organisations working to improve young people's mental health and wellbeing that stressed how important education was to recovery:

> Increased participation in education has been shown to improve the well-being of young people.[10]

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5 Assoc. Prof. Killackey, OYH, *Committee Hansard*, Melbourne, 13 April 2011, p. 18; Psychosocial Research Centre, *Submission 33*, p. 1; Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 14 October 2011, p. 2.

6 Assoc. Prof. Killackey, OYH, *Committee Hansard*, Melbourne, 13 April 2011, p. 18.

7 OYH, *Submission 28*, pp. 2-3.

8 For instance, Parliamentary–in-confidence, *Submission nos. 11, 12, 14, 45.*

9 Assoc. Prof. Killackey, OYH, *Committee Hansard*, Melbourne, 13 April 2011, p. 18.

10 Inspire Foundation, *Submission 72*, p. 4.

Increasing prevalence

2.10 Mr Stephen Bailey, a student support service officer at Macquarie University, stated that he had attended an Asia Pacific Student Services Association conference in 2011 at which concerns were expressed by many attendees about the large numbers of university students with a mental illness:

> At Macquarie, according to my latest figures, over 35 per cent of students with our disability service have a mental illness ... I was told by a colleague at Wollongong that it is about that figure [mid-forties].[11]

2.11 Ms Debi Toman, one of 31 Australian Government-funded National Disability Coordination Officers, whose role is to enhance education and employment opportunities for people with disabilities, confirmed that the number of students with mental illness at university has been steadily increasing in recent years. In her experience, approximately 30 per cent of students registering with Disability Liaison Officers (DLOs) and seeking support and services would have mental illnesses.[12]

2.12 While applauding the increased participation of students with mental illness in further education, Mr Bailey claimed it is a problem about which universities do not really know what to do.[13]

2.13 Beyond Blue stated that while TAFEs and universities are confronting the larger numbers of students coming through with mental health issues:

> [they] are probably where secondary schools were 10 years ago ... They are very much in the early days [of dealing with the issue] ... In Australia the primary school sector and secondary school sector has gone much further around this.[14]

2.14 Some university student services staff spoke of heavy counselling workloads, including catering for increasing numbers of lower socio-economic status students, who they say, are especially prone to stress related and anxiety conditions:

> They cannot afford to go to regular GPs or counselling unless it is free. They seem to tip over into stress related conditions because

11 Mr Stephen Bailey, private capacity, *Committee Hansard*, Sydney, 17 June 2011, p. 16.

12 Personal communication by email to committee secretariat, 6 March 2012.

13 Mr Bailey, private capacity, *Committee Hansard*, Sydney, 17 June 2011, p. 16.

14 Mr Brian Graetz, Program Director, Education and Early Childcare, Beyond Blue, *Committee Hansard*, Melbourne, 19 August 2011, p. 5.

> they have cars that are not reliable, multiple children with different illnesses and they are often sole parents.[15]

Factors inhibiting participation in and completion of education

2.15 Some of the barriers to participation in and completion of education for those with mental ill health may include anxiety about taking public transport to large, potentially intimidating, campus environments. Inflexible course structures can present an additional obstacle. For instance, having to attend classes that start early in the morning can be very difficult for young people waiting for their medication to take effect or for side effects such as drowsiness to wear off. Missed classes can result in falling behind in coursework and lower grades. Students may be reluctant to seek help from teachers or counsellors, or face discrimination from staff and students alike when they do disclose their illness. The practical supports they require may also not be readily available in their place of study.

Bullying

2.16 It is well-established that bullying at school, including cyber-bullying and students using mobile phones to harass one another can also contribute to poor education outcomes and mental ill health.

2.17 Mr Harry Marks from Uniting Care Wesley Port Adelaide described the huge impact bullying has had on some of the boys he works with in Whyalla:

> With a couple of my lads a lot of things that are going on now go back to bullying at school ... these lads were picked on when they were young, and it rolled over and over and over ... and that is where it starts.[16]

2.18 Mrs Marie Kuchel, a colleague from UnitingCare agreed:

> When they are at school and having trouble with bullying ... they are pushed to the side. They just go through the system and it is easier to drop out than it is to fight back.[17]

15 Mrs Jean Packham, Student Counsellor Facilitator, Charles Darwin University (CDU), *Committee Hansard*, Darwin, 17 October 2011, p. 2.

16 Mr Harry Marks, Business Supervisor, Wesley Social Enterprises, UnitingCare Wesley Port Adelaide, *Committee Hansard*, Whyalla, 6 June 2011, p. 7.

17 Mrs Marie Kuchel, Program Manager, UnitingCare Wesley Port Adelaide, *Committee Hansard*, Whyalla, 6 June 2011, p. 7.

2.19 Other mental health consumers cited similar experiences:

> At school it was hard because I was bullied. People can tell by looking at you [that you have a mental illness]. People's attitudes can make you feel welcome or not (Mental Health Consumer, 2011).
>
> My mental illness developed because I was bullied a lot at my high school and the teachers etc did nothing about it...[18]

Uneven spread of services across the country

2.20 It is a well-established fact that there is an uneven spread of services available to people across Australia. Young people in metropolitan areas generally have better access to specialist mental health and employment services than their peers in regional and remote areas.

2.21 There is a stark contrast between the comprehensive suite of assistance able to be offered by an organisation like Orygen Youth Health, located in inner Melbourne and the regions. For instance, one carer spoke of the enormous difficulties she faced in getting help for her son in Darwin, and having to go to great lengths to obtain a place for him in a specialist clinic in Sydney.[19]

2.22 Miss Nicole Cox, a National Disability Coordination Officer in WA, spoke of her experience in regional and remote parts of northern Western Australia and the scarcity of services there for people:

> In the Kimberley the rate of mental health issues is about 1.5 times higher than the rest of the country ... 70 per cent of hospital admissions for mental health in the Kimberley are Indigenous ... and the suicide death rate is 2.3 times higher than for the state population...
>
> There is one disability employment service in Broome...
>
> There are many students and young people with mental health issues who are not being identified by the schools. It is a huge issue that kids in the Kimberly go right through school with problems. Diagnosis and referrals are not happening ...

18 NSW Consumer Advisory Group, *Submission 42*, p. 19.

19 Mrs X, Carer, *Committee Hansard*, Darwin, 17 October 2011, pp. 14-15.

> Schools are often serviced by a visiting psychologist ... [but access is prohibited during the wet season, some 3-4 months of the year].[20]

Importance of early intervention and prevention

2.23 Throughout the inquiry, it was repeatedly put to the Committee that evidence strongly supports early intervention and prevention.[21] This is perhaps especially true with education and identifying students who are starting to fall behind.

2.24 The latest OECD research calls for early intervention, especially during adolescence when the onset of mental disorders is prevalent. The OECD advocates:

- preventing mental disorders at an age when adolescents attend school or underdo an apprenticeship, with early intervention and referral to services as appropriate;
- intervening early and assertively for pupils who display behavioural problems, and thereby, preventing school drop-out;
- assuring better education outcomes for early school leavers who are particularly at risk of developing mental health problems, through apprenticeships and second-chance school programmes; and
- helping youth with mental disorders in their transition from adolescence to adulthood and from mandatory to higher education and into employment.[22]

2.25 The remainder of this chapter examines the different ways that a range of educational institutions, schools, tertiary institutions and registered training organisations assist students who are exhibiting signs of a mental illness and, moreover, promote the mental health of all students, and what more might be done in both areas.

Prevention, promotion and early intervention in schools

2.26 The Australian Psychological Society states how critical it is to promote good mental health from a very young age:

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20 Miss Nicole Cox, National Disability Coordination Officer, Edge Employment Solutions, *Committee Hansard*, Perth, 18 October 2011, p. 26.

21 For instance, OYH, *Submission 28*; Mental Illness Fellowship South Australia (MIFSA), *Submission 17*; Mr Bailey, private capacity, *Committee Hansard*, Sydney, 17 June 2011, p. 21.

22 OECD, *Sick on the Job? Myths and Realities about Mental Health and Work,* December 2011, pp. 207-208.

> Promoting effective social and emotional competencies such as self awareness and self management will assist children to develop skills in coping, as well as being able to seek help, when necessary ... The promotion of good mental health in early childhood years will reduce risk and promote resilience in ongoing development.[23]

2.27 DEEWR stated that the Commonwealth Government recognises this, which has been reflected in a focus on services designed to reach out to children and young people.[24]

2.28 Following a successful pilot evaluation, the Australian Government will invest $ 18.4 million over four years from 2010-2011 to roll out Kidsmatter Primary, a flagship national initiative that helps primary schools implement evidence-based mental health promotion, prevention and early intervention strategies by:

- improving the mental health and wellbeing of primary school students;
- reducing mental health problems amongst students; and
- achieving greater support for students experiencing mental health problems.[25]

2.29 A list of the current participating schools in each state and territory (including the 101 schools who participated in the pilots from 2007-2008) is available from the website.[26]

2.30 Two other Kidsmatter initiatives are being piloted at sites across Australia. Kidsmatter Early Childhood is a national early childhood mental health promotion, prevention and early intervention initiative specifically developed for early childhood services including preschools and long daycare, which is being piloted at 100 preschools and long day care centres.[27]

2.31 Kidsmatter Transition to School supports the transition to primary school from preschool and long day care. It consists of four information sessions developed for school staff to deliver to parents and carers to support their child starting school.[28]

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23 Australian Psychological Society, *Submission 40*, p. 11.

24 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard*, Canberra, 14 October 2011, p. 2.

25 Kidsmatter website, http://www.kidsmatter.edu.au/primary/content/uploads/2011/10/KidsMatter-Overview-2009.pdf

26 Kidsmatter website, http://www.kidsmatter.edu.au/primary/kidsmatter-overview/participating-schools

27 Kidsmatter website, http://www.kidsmatter.edu.au/ec/

28 Kidsmatter website, http://www.kidsmatter.edu.au/

2.32 Kidsmatter programs are characterised by collaborative partnerships with other organisations, including Early Childhood Australia, Principals Australia, the Australian Psychological Society and Beyond Blue.[29] Schools can make connections with community mental health and support services and establish referral pathways, through those contacts, for students experiencing mental illness.[30]

2.33 Utimately, the Kidsmatter programs are about:

> Involve[ing] the people who have a significant influence on children's lives – parents, carers, families, child care professionals, teachers and community groups- in making a positive difference to children's health.[31]

2.34 The Australian Psychological Society endorsed Kidsmatter but expressed concern that there is neither a similar commitment in high schools, nor sufficient support to cater for the transition from high school to further education or employment.

> We have the older secondary students, adolescents who are at a pretty vulnerable time, leaving school with really no support. [32]

2.35 While high schools generally have chaplains or counsellors to help students deal with mental health issues during this time and access to external providers if necessary, there appears to be a gap and space for a follow on from Kidsmatter Primary to a Kidsmatter High Schools equivalent or complement.

2.36 Given that adolescence is when mental illness often first strikes, a Kidsmatter High Schools program or equivalent could be a very timely intervention tool.

2.37 The Committee notes the successes of the Kidsmatter Primary Program and supports the initiation of a Kidsmatter High School pilot based on similar principles. The Kidsmatter High School program could assist students' transition from primary to high school and with the very important transition from secondary school to further education, training and work. It could complement the Australian Government's new anti-

29 Kidsmatter website, http://www.kidsmatter.edu.au/

30 Kidsmatter website, http://www.kidsmatter.edu.au/primary/resources/enewsletter-archive/september-news/

31 Kidsmatter website, http://www.kidsmatter.edu.au/

32 Dr Rebecca Matthews, Manager, Practice Standards and Resources, Australian Psychological Society, *Committee Hansard*, Melbourne, 19 August 2011, p. 31.

bullying campaign, Bullying No Way which offers advice and an array of resources to help students, teachers and parents stop bullying.[33]

Recommendation 2

The Committee recommends that the Commonwealth Government establish a Kidsmatter High School program pilot based on similar principles to the Kidsmatter Australian Primary Schools Mental Health Initiative.

Supports during high school

> We need to promote mental health at grassroots level, particularly in high schools.[34]

2.38 One witness offered high praise of her high school counsellor:

> It was during high school that I started having mental health issues. I relied on my school counsellor alot. She got me through high school. ..I found [her] amazing ... really supportive and happy to see me when I was not feeling great ... She supported me through [suicidal thoughts]. She even got the school to participate in suicide awareness day. That made me feel really supported as well. Seeing all the other kids doing that was fantastic.[35]

2.39 Some schools are making concerted efforts to promote the mental health and wellbeing of their students. The Committee visited the Rothwell Campus of the Grace Lutheran College on 9 August 2011 in order to meet staff and students from the middle and senior schools to discuss their approach.

2.40 In addition to the provision of school counselling and pastoral care services, the school held its first Healthy Minds Expos in July 2011, involving key Brisbane youth support agencies such as Kids Help Line, Life Line, Drug Arm, Eating Disorders Australia, Youth Space, Child and Youth Mental Health Services and Cruise (self-harm). The Committee was shown the students' school diaries which contain strategies for

33 See Bullying No Way website, http://www.bullyingnoway.gov.au/

34 Mr Jim Buultjens, Chief Executive Officer, Fairhaven Services, *Committee Hansard*, Gosford, 30 August 2011, p. 1.

35 Miss A, Ex-client of OYH, *Committee Hansard*, Melbourne, 13 April 2011, p. 21.

maintaining good mental health at the front, together with helpline contact numbers for the agencies that presented at the Expo.[36]

2.41 The purpose of the Healthy Minds Expo was to host a whole-of-school event that showcases a broad range of mental health professionals and organisations to the school community. The impetus for the expo was to try and break the stigma attached to seeking out help for mental health issues. Conducted over the course of a day, each year level browsed the host's displays and had an opportunity to talk with them about their specific services. Workshops were also run by select service providers on topics such as drug and alcohol abuse, grief and loss, anxiety and depression, taking care of your mates, body image and self-esteem and building a robust resilience.[37]

2.42 Ms Ruth Butler, School Principal, together with Mr Dale Dearman, the school counsellor (who was responsible for organising the Expo) and college students reported that the expo was a great success. So much so that the school envisages making it an annual fixture on the school calendar.[38]

2.43 Other Grace Lutheran initiatives include seminars on teenage depression and various programs at different year levels to boost students' self esteem and, coping, communication and interpersonal skills. Support for staff is also on offer with a Burnout Seminar and plans to run courses for them in counselling and life skills.[39]

2.44 Students enthusiastically articulated some of the benefits of the programs at their school. These included increased confidence in discussing their problems and knowing how to access help for themselves, their friends and other students who might be struggling with personal issues.[40]

2.45 Central to the school's successes in these areas is the dedication and drive of the school counsellor:

> My passion lies in helping others see that good mental health is really everyone's business.[41]

2.46 Support from the principal and other staff is also integral.

2.47 Another example of a school's 'positive education' approach to mental health is provided by the Headmaster at Knox Grammar School. Mr John Weeks describes his school's proactive approach:

36 Site inspection, Grace Lutheran College, 8 August 2011.

37 Mr Dale Dearman, School Counsellor, Grace Lutheran College, Brisbane, *Exhibit 25.*

38 Site inspection, Grace Lutheran College, 8 August 2011.

39 Mr Dale Dearman, Grace Lutheran College, Brisbane, *Exhibit 25.*

40 Site inspection, Grace Lutheran College, 8 August 2011.

41 Mr Dale Dearman, Grace Lutheran College, Brisbane, *Exhibit 25.*

> The program [implemented with expert input from the Positive Psychology Institute in Sydney] aims to equip students with the skills for mental fitness to ensure they perform at their very best and are resilient to the stresses they may encounter as teenagers and young adults, such as relationship challenges and academic pressures.
>
> All staff are receiving training in positive education to encourage positive culture in every aspect of school life.
>
> ...Students receive one-on-one mentoring from one of our teachers. That same mentor will stay with the student throughout their time at the school, building a close relationship with the student and his parents....The program has also helped our students identify their strengths and set their personal goals.[42]

2.48 Mr Weeks said that the University of Wollongong is reviewing the program and that feedback from students and teachers alike 'so far has been encouraging.'[43]

2.49 Acknowledging that Knox has the resources available to it to conduct the program that perhaps other schools may not have, Mr Weeks emphasised that this preventative program is an exemplar, which has the potential to be replicated by other schools and government.[44]

Alternative high school models

> ...being provided with an option that works for you, 'one size does not fill all.'[45]
>
> We have very passionate staff ... it is so inclusive.[46]

2.50 The Committee saw equally high levels of passion, dedication and drive to looking after the mental health and wellbeing of young people demonstrated in two other contexts. These were two successful alternative high school models that cater for high school-aged children who find themselves outside the mainstream education system.

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42 John Weeks, 'Right programs can storm-proof kids' in The Sydney Morning Herald, 30 April 2012.

43 John Weeks, 'Right programs can storm-proof kids' in The Sydney Morning Herald, 30 April 2012.

44 John Weeks, 'Right programs can storm-proof kids' in The Sydney Morning Herald, 30 April 2012.

45 Respondent in Australian Youth Forum, *Submission 73*, p. 14.

46 Ms Meredith Milne, Youth Transitions Executive Officer, Youth Connections (YC), *Committee Hansard*, Gosford, 30 August 2011, p. 22.

ALESCO learning centre and Green Central

2.51 Funded through the DEEWR Jobs Fund,[47] to create employment opportunities for young people on the Central Coast of New South Wales (an area of high youth unemployment and disadvantage), Green Central is described as 'a new school that isn't like a school':

> The site was retrofitted and refurbished using [42] apprentices and trainees under mentorship from skilled tradesmen, and became a space for social enterprises, a sustainable house, Indigenous Skills Centre, Media Centre, horticulture and classrooms ... .It's about chances and second chances and maybe even third [chances].[48]

2.52 Ms Meredith Milne, from Youth Connections[49] described the way in which Green Central supports young people who have a mental health issue:

> the model [provides a] a holistic centre [with up to 100 people on site each day] where you have a number of wraparound services and people supporting those young people to be successful in education, moving through to training and then employment there or future employment outside of there … We actually have the partnership brokerage contract and the connections contract under our organisation and that also supports the model. The partnership brokerage is about getting the partners together for it and the Youth Connections program has the youth workers who support the young people and the referral systems here.[50]

2.53 Designed for young people aged 14 to 17 years who have dropped out of mainstream schools for a host of reasons that might include criminal convictions, drug and alcohol addictions, homelessness and family breakdown, the ALESCO Learning Centre, co-located at Green Central, is an independent college for the completion of years 9 and 10. The school 's difference lies in its teaching methods and delivery of education to students:

> The greatest difference between us and many other alternative education settings is our foundations lie in Adult Education philosophies. Freedom of thought, mutual respect, responsibility all have a significant role to play.

47 DEEWR, Department of Health and Ageing (DoHA) and Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), *Submission 62*, p. 29; DEEWR website: http://www.deewr.gov.au/employment/pages/jobsfund.aspx

48 YC website, http://www.youthconnections.com.au/green_central.php

49 Youth Connections is an organisation that helps young people aged 13-19 on the Central Coast access education, training and recreational opportunities so that they can reach their potential.

50 Ms Milne, YC, *Committee Hansard*, Gosford, 30 August 2011, pp.20 and p. 23.

> Smaller class sizes allow students greater opportunity to identify their strengths and work to improve the areas in which they lack confidence.
>
> We also have youth support workers available to work with the students who feel extra support is needed. [51]
>
> Students get to call their teachers by their first names and don't have to wear a uniform.[52]

2.54 In addition to the school, there are school-based apprenticeship and trainee opportunities offered in conjunction with the automotive and other trade workshops co-located on-site. Traineeships are also available in horticulture and hospitality, with gardens, a glasshouse and cafe also located on site for students aged up to 19 years to gain practical skills.

2.55 The Coolamon training cafe adjoins the Indigenous Skills Centre, and employs and trains Aboriginal women and young people. Gunya Flavours Bush Tucker Catering operates out of the cafe and uses native plants from the gardens in its recipes.

2.56 There is also a community radio station with media production facilities.

2.57 Young people get paid work experience through YG Enterprises, a registered business offering services in mechanical repairs, car-washing concreting, landscaping, shop fitting, carpentry, general maintenance and labour hire, all carried out to Australian standards.[53]

2.58 The Committee spent a morning at the Green Central campus touring the different facilities and talking to the CEO, Mrs Maggie MacFie and key personnel, including the Chair, Mr David Abrahams, Indigenous Cultural Advisor and Tourism, Mr Gavi Duncan, Transitions, Ms Meredith Milne, and Social Enterprise, Mr Brendan Ritchens, and students.

2.59 Ms Milne from Youth Connections described the students from Green Central as having come to them completely disengaged from the traditional education system.[54]

2.60 Staff recounted how students who had barely been able to make eye contact when they first started had, throughout the course of the year, become increasingly confident communicators. They said that not only did students turn up every day on time but they found many did not want to leave at the end of the day. The apprentices and trainees enjoy practical learning, working with their hands in the workshops and going off-site to

51 ALESCO School Prospectus, http://www.alesco.nsw.edu.au/pdf/Student%20Prospectus.pdf

52 ACE North Coast Community Colleges, ALESCO Learning Centre, http://www.acecolleges.edu.au/special-programmes/alesco/p/216

53 YC website, http://youthconnections.com.au/yg_enterprise.php

54 Ms Milne, YC, *Committee Hansard*, Gosford, 30 August 2011, p. 21.

do real jobs in the real world. Several students spoke enthusiastically about their plans for further training, getting jobs with local employers assisted through contacts made on work placements and the future in general.[55]

2.61 Formerly disengaged young people provided positive reflections on their Green Central experience:

> 'I really learnt how to communicate with others'—Ashley
>
> ' ... the outcome was that most of us got full-time jobs. It gave you that experience on a job site that employees were looking for ... I wouldn't want to change [the GC model] because I would want young guys to have the same fun that I did. Learning should be fun ... ..My mum's heaps proud now.' Aaron
>
> 'It helped me learn what skills I need for a job and also skills for life ...
>
> It made me feel like I'm working to my best ability and I'm really proud of that ...
>
> [If GC never existed] I'd probably still be going to Centrelink getting payments ... no more, now I just get my fortnightly payment that I worked for.'—Mark[56]
>
> I'm interested in continuing education through TAFE/OTEN, I had good experiences with ALESCO.[57]

2.62 Mr Ashley McGeorge, Transitions Manger, summarised the benefits of the Green Central model:

> Getting the guys engaged in the different industries gives them a purpose in their life and gives them hope at the end of the day. If you do not have hope your heart is going to be sick ... It gives the guys something to look forward to ... a pathway for their future.[58]

2.63 Ms Milne described the impact the Youth Connections media program had had for Matt, one of the enthusiastic media trainees whom the Committee met at the Green Central radio station:

> If you had met him two or three years ago, he had major depression. He could not leave the house very often ... So it is good

55 Site inspection, Green Central, Gosford, 30 August 2011.

56 Green Central Annual Report 2010-2011, http://issuu.com/youthconnections.com.au/docs/annualreport20102011

57 NSW Consumer Advisory Group, *Submission 42*,p. 19.

58 Mr Ashley McGeorge, Transitions Manager, YC, *Committee Hansard*, Gosford, 30 August 2011, p. 21.

> to see what has helped him so much being in that sort of environment.[59]

2.64 The inclusive atmosphere at Green Central gently encourages rather than forces interactions, not just between staff and young people but also between young people themselves. Ms Thomas recounted how she had brought in a young person recently who had anxiety so severe that they had not been able to attend school for a year but another young person in the automotive workshop had struck up a conversation with them about what they could do if they came and worked there.[60]

2.65 Ms Milne summarised the wide range of factors she believes contribute to Green Central's success:

> ... we have very enthusiastic staff ... we already had the background of working with young people in schools, we identified the need and saw the gaps ... .the vision of having a space where young people could come to and have that pathway of education and support networks ... they get hands-on experience in horticulture, in hospitality, in mechanics.
>
> You have got people with many different levels of ability all working together with support of a lot of tradespeople and mentors and professionals doing their bit but without the young people even knowing that somebody is helping them.[61]

2.66 The Green Central model is but one operating on the Central Coast keeping students in school. Youth Connections outlined a range of other strategies they employ to try and keep kids in schools:

> We have five youth workers who work in schools to keep kids in education ... and we work with the kids who've slipped away already [by referring them to Green Central].[62]
>
> School based apprenticeships or traineeships if that is possible ... looking at negotiated attendance with other community programs if that may be appropriate ... the schools are becoming a lot more flexible ... We also have another program called transition that is for kids not ready for ALESCO.[63]

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59 Ms Milne, YC, *Committee Hansard*, Gosford, 30 August 2011, p. 22.

60 Ms Linda Thomas, Team Leader YC Program, YC, *Committee Hansard*, Gosford, 30 August 2011, p. 22.

61 Ms Milne, YC, *Committee Hansard*, Gosford, 30 August 2011, p. 22.

62 Ms Milne, YC, *Committee Hansard*, Gosford, 30 August 2011, p. 20.

63 Ms Milne, YC, *Committee Hansard*, Gosford, 30 August 2011, p. 21.

Links with employment services

2.67 Ms Milne explained that youth workers in her team work together with Centrelink and JSA providers to help youth in the area who leave or are not part of Green Central and are struggling with getting employment and training.[64]

2.68 Ms Linda Thomas, Team Leader, YC Program, mentioned a new partnership with the specialist employment services provider ORS Group, to assist young people with basic work readiness skills:

> They are seeing that those kids who come to us and to them are not ready to go into courses. We are just setting them up to fail because they are not ready for that step. So we are sort of stepping back a bit to do a little more therapeutic stuff, do that self-esteem and life skills and those things.[65]

Future scope

2.69 Youth Connections is looking to expand and intensify the nature of its operations.

2.70 According to Youth Connections, there is a need for additional services, similar to the kinds already on offer at Green Central in the wider region. Ms Milne commented: 'We are not even touching the sides on those that are living up north.'[66]

2.71 She indicated that Youth Connections were looking at ways to take the Green Central concept further, similar to what is being done overseas, by also providing jobs on site:

> Those young people, if they were getting paid to be there because they were doing a job to make that place even better, it would just give them so much on so many levels.[67]

Australian Industry Trade College

2.72 Another non-traditional model of education that is having success with students that might not otherwise finish high school, including those suffering from a mental illness, is the Australian Industry Trade College (AITC). The Committee visited the AITC on the Gold Coast on 8 August 2011.

2.73 First established in 2008, the AITC prepares year 11 and 12 students for a career in industry with a dual emphasis on completion of their

64 Ms Milne, YC, *Committee Hansard*, Gosford, 30 August 2011, p. 20.
65 Ms Thomas, YC, *Committee Hansard*, Gosford, 30 August 2011, p. 21.
66 Ms Milne, YC, *Committee Hansard*, Gosford, 30 August 2011, p. 23.
67 Ms Milne, YC, *Committee Hansard*, Gosford, 30 August 2011, p. 22.

Queensland Certificate of Education (QCE) and an apprenticeship/traineeship in a trade. Each year, 150 young people commence year 11 studies.[68]

2.74 Students attend school lessons in four week blocks at the AITC campus followed by four week blocks of work in their chosen industry. The unique four week blocks allow employers to sign two apprentices in back-to-back blocks providing an apprentice on site at all times.[69]

2.75 The school places an emphasis on preparing students for 'the real world' and, like Green Central, instils core values like respect. Students (also referred to as team members) call teachers (also referred to as team leaders) by their first name. They are trained to be work ready with a flexible timetable especially designed to give students a head start into an apprenticeship at the same time as completing their senior education.[70]

2.76 Students can additionally elect to undertake a Certificate II in business and information technology and first aid certification.[71]

2.77 The AITC website states that over 480 Australian school based apprenticeships have been created in the past three years (since the school opened). Further, 100 of AITC students achieved the Queensland Certificate of Education in 2010.[72]

2.78 The Committee spent a morning touring the college facilities and holding discussions with the CEO, Mr Mark Hands, Director of Education, Ms Tricia Mason-Smith, Director of Industry and Training, Mr Jason Sessarago, teachers and students.

2.79 The Committee learnt that dedicated employment consultants work hard to establish and maintain industry contacts.

2.80 A dedicated case manager also supports each student through the process of entering the workforce and becoming a school-based apprentice. The college provides networking opportunities and the student is encouraged and expected to be part of the process of seeking out their own employment.[73]

2.81 Students enthused about the broad range of trades they are studying for in the following areas: automotive, hospitality, engineering, building and construction, electro-technology and hairdressing.

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68 "Your teenager's future trade career begins here," General Information, AITC brochure, pp. 2-3.

69 "Your teenager's future trade career begins here," General Information, AITC brochure, p. 4.

70 "Your teenager's future trade career begins here," General Information, AITC brochure, p. 4.

71 "Your teenager's future trade career begins here," General Information, AITC brochure, p. 3.

72 AITC website, http://www.aitc.qld.edu.au/about-australian-technical-college.php?nav=3

73 Site inspection, AITC, Gold Coast, 8 August 2011.

2.82 Students clearly enjoy the dual aspects of their education and trade training, the courses' flexibility, and the fact that they are learning and getting paid to do something that they enjoy and can see a future for themselves in.[74]

Finding a vocation, life-skills and holistic health

2.83 Green Central and AITC are two approaches to keeping students engaged in education to attain basic qualifications at the same time as encouraging them to discover a vocation, rather than just getting a job for the sake of it.

2.84 The Committee heard compelling evidence from Professor Peter Butterworth at the Australian National University that unsatisfactory employment is as much a risk factor for mental health as unemployment:

> In some recent analysis of data from the HILDA survey following around 7500 working-age Australians over seven years, we found that people who moved into poor-quality jobs – which we defined as being insecure jobs; those that had intense, unmanageable demands; those with low levels of autonomy, low levels of control in the workplace; and those that were paid unfairly – actually had the same or poorer mental health than people that were unemployed.
>
> In contrast, people who moved into better quality jobs showed significant improvement in mental health.[75]

2.85 At both Green Central and the AITC, the Committee was struck by the visionary ways that students are supported to discover their vocation by dedicated personnel who understood teenagers, and, in some cases, brought to bear their own personal experience with youngsters with a lived experience of mental illness.

2.86 It was clear from the Committee's visits that both campuses believe wholeheartedly in supporting and nurturing the future aspirations and wellbeing of the individual as well as cultivating a sense of community.

2.87 Both Green Central and AITC pay attention to critical transition periods for students, into the school and training environments and beyond them.

2.88 AITC offers induction camps for incoming students[76] to help prepare them for the commencement of their studies and as an opportunity to meet other students and make friends.

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74 Site inspection, AITC, Gold Coast, 8 August 2011.

75 Associate Professor Peter Butterworth, National Health and Medical Research Council (NHMRC) Principal Research Fellow, Centre for Mental Health Research, Australian National University (ANU), *Committee Hansard*, Canberra, 13 May 2011, p. 21.

76 AITC website, http://www.aitc.qld.edu.au/upcoming-events.php?nav=12

2.89 A central premise of Green Central and AITC alike is brokering partnerships with local employers and organisations to help find and sustain job opportunities for their graduates.

2.90 Campus ceremonies and events that bring the student body together to celebrate students' achievements are a feature of both the AITC and Green Central. The Committee participated in an Aboriginal smoking ceremony at Green Central, one of the regular activities led by Indigenous staff for the Green Central community to keep local traditional ways alive and as a form of cleansing, healing and restoration.

TAFEs and universities – a mixed picture

> I think it is really good that at my university they have a focus on mental health rather than just the physical side of things.[77]
>
> The flexibility and counselling at TAFE is helpful.[78]

2.91 Some universities are making a real commitment to the inclusion of students with a mental illness.

2.92 Leadership is imperative. Mr Steven Bailey a student services officer at Macquarie University in Sydney spoke of the strong commitment from Macquarie's Vice-Chancellor, and even having a dedicated Pro Vice-Chancellor for social inclusion and equity.[79]

2.93 The Australian National University student services recently created a position of Mental Health Advisor at its campus:

> Responsible for the development of a number of proactive mental health initiatives and processes that will be used to inform the university community and to respond more effectively to an increase in serious mental health issues ... the Mental Health Advisor will work closely with the Head of Counselling and Disability Services, other student services staff and other areas of the university to further develop these strategies.[80]

2.94 Miss A described her experience with the senior disability liaison officer at her university:

> She is very mental health aware. She had posters with Orygen, Kids Helpline and everything in her office. I could not speak too

77 Miss A, Ex-client of OYH, *Committee Hansard*, Melbourne, 13 April 2011, p. 21.

78 NSW Consumer Advisory Group, *Submission 42*, p. 19.

79 Mr Bailey, private capacity, *Committee Hansard*, Sydney, 17 June 2011, p. 16.

80 ANU website, Current vacancies, http://jobs.anu.edu.au/PositionDetail.aspx?p=2511, viewed 17 January 2012.

> highly of her. She helped me when I had an inpatient stage. She helped me talk to lecturers to tell them I am not going to get something in because I am in hospital or not too crash hot. She is easy to access through email and telephone.[81]

2.95 Mr David Munro, a Vocational Education Training (VCE) student at the Charles Darwin University (CDU) also reported a positive experience with student services:

> My experience in going to them when I have been really stressed out has been good. [82]

2.96 Other students offered more reserved assessment of support services. Ms Sarah Reece said:

> I found the support at university was primarily geared for people with physical mobility issues and not so much for people with mental health problems ... without any support on site … I withdrew.
>
> The general attitude I encountered at university was that I should go away and get better, and then I should come back and reengage. The problem is that reengaging is part of getting better and, to a certain extent, there are some things that are not going to get better – they are things I am going to have to live with and learn to manage.[83]

2.97 Miss Reece described difficulties she had encountered in finding out what services existed to help her recover from her mental illness, from either her university counsellor, or prior to that her school counsellor (she was first diagnosed aged 15). She and Mental Illness Fellowship Australia (MIFSA) suggest that her university and school could have better assisted her by linking her into local services through referral to an organisation such as MIFSA.[84]

2.98 Another student noted that the transition for them was difficult:

> At school I had support networks in place (like a school counsellor, school nurse and youth mental health worker)...when I finished school, all these support networks were cut off ...at university there are measures in place for students who are

81 Miss A, Ex-client of OYH, *Committee Hansard*, Melbourne, 13 April 2011, p. 21.

82 Mr David Munro, Student, CDU, *Committee Hansard,* Darwin, 17 October 2011, p. 2.

83 Ms Sarah Reece, Participant, PHaMs West Program, *Committee Hansard*, Adelaide, 7 June 2011, p. 3.

84 Ms Reece, Participant, PHaMs Program, *Committee Hansard*, Adelaide, 7 June 2011, p. 3.

> mentally ill, but in reality, in my opinion, it wasn't very supportive. So I struggled to the point where I left university.[85]

2.99 In relation to the vocational education sector, Mrs Michelle Bell, Assistant General Manager, Employment Services, ORS Group stated that TAFEs:

> ... are very good with physical disabilities but not as much with mental health.[86]

Professional development for teaching staff and general awareness of student welfare services on campus

2.100 Several witnesses referred to a general lack of understanding at their schools or tertiary institutions about mental illness and, that subsequently there needs to be education of both staff and students.[87]

2.101 At Macquarie University measures to counter stigma amongst the teaching faculty comprise the following:

> We provide formal training for academics. We are putting together a series of short films. We have made a nice little film called *Jenny's Story* about anxiety, which is available on the university website...
>
> We have a very well-run Learning and Teaching Centre where we provide information to staff. So there is some very simple information that we are giving to staff just by constantly educating and working with them.[88]

2.102 Charles Darwin University (CDU) has no formalised activities, although that is something on the future agenda. Further, a high level committee is to be established at the university to oversee staff professional development:

> And that would incorporate that awareness around health issues, whether they are mental health or other ... .we are trying to take that responsibility away from the individual in that role [the disability liaison officer] and make it university wide and the responsibility of a range of people.[89]

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85 NSW Consumer Advisory Group, Su*bmission 22*, p. 19.

86 Mrs Michelle Bell, Assistant General Manager, Employment Services, The ORS Group, *Committee Hansard*, Gosford, 30 August 2011, p. 17.

87 Site inspection, MIFSA, Adelaide, 7 June 2011; Ms Reece, Participant, PHaMs West Program, *Committee Hansard*, Adelaide, 7 June 2011, p. 4.

88 Mr Bailey, private capacity, *Committee Hansard*, Sydney, 17 June 2011, p. 18.

89 Ms Kerrie Coulter, Disability Liaison Officer, CDU, *Committee Hansard*, Darwin, 17 October 2011, p. 4.

2.103 Ms Nita Schultz of the Victorian TAFE Association referred to some of the professional development opportunities available to the VET sector in Victoria, through the Tafe Development Centre (TDC). She said of one course on 'supporting students at risk', while not specifically mentioning students presenting with a mental illness, this would be raised in the workshop.[90]

2.104 Mrs Packham, Student Counsellor at CDU, said that faculty staff often referred students to their services, with a phone call, and that this level of referral had remained steady or increased.[91]

2.105 Mr Bailey at Macquarie University believes that student services staff need to be more visible on campuses:

> We can all use email and telephone but I encourage my staff to get out, visit and talk to people [about what we do in student services].[92]

Stigma

2.106 Mr Bailey was one of many people throughout the inquiry to say that: 'The biggest issue with mental illness is stigma.'[93]

2.107 While educating and informing academics and teaching staff in educational institutions about mental illness is important, in Mr Bailey's words, 'there is a lot more to do'.[94] He praised the public education campaigns rolled out in New Zealand that feature well-known figures, including young sporting personalities: 'Talking about mental illness ... destigmatising and normalising it.'[95] In Australia, by contrast, he intimated, there are fewer positive public role models for mental illness.

2.108 The New Zealand 'Like Minds, Like Mine' campaign was explored in chapter one of this report, with a recommendation to the Commonwealth Government to initiate a similar scheme here.

2.109 A 'Like Minds Like Mine' style campaign should include involvement from the university and vocational education sectors, individually or collectively through representative bodies, to run education campaigns across campuses.

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90 Ms Nita Schultz, Executive Officer CEO Council, Victorian TAFE Association, *Exhibit 40,*email.

91 Mrs Packham, CDU, *Committee Hansard*, Darwin, 17 October 2011, p. 2.

92 Mr Bailey, private capacity, *Committee Hansard*, Sydney, 17 June 2011, p. 18.

93 Mr Bailey, private capacity, *Committee Hansard*, Sydney, 17 June 2011, p. 18.

94 Mr Bailey, private capacity, *Committee Hansard*, Sydney, 17 June 2011, p. 19.

95 Mr Bailey, private capacity, *Committee Hansard*, Sydney, 17 June 2011, p. 19.

Student support services

2.110 Student support services at universities and TAFEs comprise general counselling and disability liaison services (a Disability Liaison Officer (DLO) or Disability Advisor). A different role is performed by each, although they may work as part of a team, together to help the student.

2.111 Ms Debi Toman, National Disability Liaison Coordination Officer for the areas of Canterbury-Bankstown; Inner Western Sydney and Central Western Sydney, and based at the University of Western Sydney, pointed to the differences. The Student Counsellor provides personal counselling, including in relation to study access issues. The DLO is responsible for arranging reasonable adjustments for all students with disabilities which includes exam conditions, alternative assessments and support services such as note-taking and alternative formats.[96]

2.112 Ms Julie Harrison, the Disability Operations Manager at the Australian National University described the Disability Advisor's role as appraising the impacts of mental health issues on learning and assessment in tertiary studies.[97] Ms Harrison observed that the role of a disability practitioner may also include assisting the organisation to develop and implement Disability Action Plans, policies and procedures to ensure that disability services are mainstreamed.[98]

2.113 Ms Toman stated that the Counselling Service and Security Staff are usually the central contacts for advice and support for staff who come into contact with students they think might be at risk of harm.[99]

2.114 She mentioned that in many situations students give permission for university staff to liaise with their DLO and/or Counsellor. Students with a mental illness often become clients of both a DLO and counsellor. She pointed to the time intensive nature of such support: often an hour long appointment with a student might necessitate hours of follow up to put the necessary services and supports in place for the student.[100]

2.115 Ms Harrison noted that while counselling staff possess formal qualifications, there is no formal qualification to be a Disability Liaison Officer. She emphasised that it is not a DLO's role to diagnose mental health but to refer on to Counselling or the medical centre for that.[101]

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96 Ms Debi Toman, National Disability Coordination Officer, Sydney, *Exhibit 38,* email.

97 Ms Julie Harrison, Disability Operations Manager, ANU, *Exhibit 39.* email.

98 Ms Julie Harrison, Disability Operations Manager, ANU, *Exhibit 39.* email.

99 Ms Debi Toman, National Disability Coordination Officer, Sydney, *Exhibit 38.* email.

100 Ms Debi Toman, National Disability Coordination Officer, Sydney, *Exhibit 38.* email.

101 Ms Julie Harrison, Disability Operations Manager, ANU, *Exhibit 39.* email.

2.116 Ms Toman said that there is no standard approach to required qualifications of DLOs. She indicated that she knew of one university that required psychology or social work degrees of their DLO and, in her experience, in addition to these two fields, DLOs tended to have qualifications in occupational therapy, speech therapy, adult education social science or leisure studies. According to Ms Toman, training of DLOs in relation to working with students with mental illness is not mandatory, but 'expected.' She indicated that in NSW, training of this nature had been provided through the Disability Education Association of NSW/ACT (DEAN).[102]

2.117 Many disability officers come from a physical disability background. One DLO related that her experience of people with a mental illness had mostly come on the job so to speak, from practical exposure over the years.[103]

2.118 According to Ms Harrison, most disability advisors have at least completed a Mental Health First Aid Course. Others have had training as part of formal qualifications they have obtained or through professional development. She concurred with Ms Toman regarding the expertise of most DLOs – saying that they tend to come into the job from a community/social work related background.[104]

2.119 Three higher education institutions provided an overview of their student support and DLO services for students with a mental illness. These were Macquarie University in Sydney; Charles Darwin University (CDU) in Darwin and Tasmanian Polytechnic.

2.120 Mr Bailey from Macquarie University outlined a broad range of pro-active student counselling, disability and welfare services provided to students at Macquarie University by student services staff.

2.121 Macquarie University's early intervention approach attempts to quickly identify those students who are starting to fall behind. There is extra assistance around exam time which is often a peak period for students to experience anxiety and depression and helping students transition to university, coaching them one-on-one or in small groups to develop the skills to manage and organise themselves.[105]

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102 Ms Debi Toman, National Disability Coordination Officer, Sydney, *Exhibit 38*, email. Note that DEAN is a network of disability services staff in universities and TAFE colleges. See website for details: http://deaninc.org.au/

103 Ms Coulter, CDU, *Committee Hansard*, Darwin, 17 October 2011, p. 2.

104 Ms Julie Harrison, Disability Operations Manager, ANU, *Exhibit 39.* email.

105 Mr Bailey, private capacity, *Committee Hansard*, Sydney, 17 June 2011, p. 19.

2.122 Mr Bailey cited the effectiveness of basic engagement such as sitting down to have meals with groups of Indigenous students when they come onto campus to attend block courses:

> They have up to four times the rate of disability of the mainstream population. Now we get large numbers of students registering with us from the Indigenous community. Just being there, being present and being available [to talk] and then providing services has made a huge difference.[106]

2.123 Mr Bailey spoke about the importance of maintaining contact with students, visiting students with a mental illness in hospital and being available for them when they return to campus, as well as working in partnership with colleagues in the mental health teams and hospitals to ensure as smooth a transition for students when they return to their studies. He gave an example of one Macquarie student who had spent months in a psychiatric unit and was discharged on a drug with heavy side effects but he was able to pass two subjects with support from student services. [107]

2.124 He also mentioned the one-on-one individual coaching provided to students with a mental illness. Mr Bailey emphasised the success of an intensive case-management approach, which is being expanded:

> ... [the one-on-one coaching] makes a huge difference. In the first semester last year of people getting that support, I had 100 per cent retention.[108]

2.125 Underpinning Macquarie's student services' provision is a belief in the importance of having mental health specialists on staff. Mr Bailey said that Macquarie has actively recruited people who have significant mental health training and experience. He said, 'this is their bread and butter' and staff 'get mental illness':

> There is no stigma – no having to educate and train ... [staff to understand about] memory loss, fatigue, lack of motivation and just how difficult it is to come into university every morning.[109]

2.126 Mrs Judith Austin, Equity Coordinator at Charles Darwin University sketched the CDU's support services which include personal counselling,

106 Mr Bailey, private capacity, *Committee Hansard*, Sydney, 17 June 2011, p. 17.

107 Mr Bailey, private capacity, *Committee Hansard*, 17 June 2011, Sydney, pp. 17-18.

108 Mr Bailey, private capacity, *Committee Hansard*, Sydney, 17 June 2011, p. 17.

109 Mr Bailey, private capacity, *Committee Hansard*, 17 June 2011, Sydney, p. 17.

a disability liaison officer, an off-campus accommodation service, international student support and careers and employment.[110]

2.127 Ms Linda Glover, Disability Liaison Officer at the Tasmanian Polytechnic explained the various ways that the TAFE supports its students with mental ill health. She described support services and teaching teams working together collaboratively with the student and their other support networks, including employment services:

> This can include case conferencing with their own support networks and with psychologists and psychiatrists. It could be with their mental health case-workers and also with employment services that they are already linked with.[111]

2.128 Mr Bailey reinforced the notion of student services working together, noting that Macquarie University was also moving to 'break down silos'. He noted that the career service was co-located:

> We are not just doing disability, counselling or welfare; we are doing all that and moving towards the employment focus.[112]

2.129 Tasmanian TAFE also works together with employment services, noting that they receive referrals from outside agencies like Workskills, a specialist disability employment service.[113]

Disability Liaison Officers

> A lot of the role is allowing [students with a mental illness] flexibility.[114]

2.130 As indicated above, an important role of the disability liaison officer is to negotiate with lecturers alternative assessment arrangements for students with a mental illness when required. This might mean organising an exam to be sat in a small room rather than a big hall, which is less overwhelming for someone with anxiety issues, or granting extensions for assignments if someone is unwell at home or in hospital) and assisting students' with time management of their assignments.[115]

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110 Mrs Judith Austin, Coordinator, Equity Services, CDU, *Committee Hansard*, Darwin, 17 October 2011, p. 1.

111 Ms Linda Glover, Disability Liaison Officer, Tasmanian Polytechnic, *Committee Hansard*, Hobart, 4 November 2011, p. 7.

112 Mr Stephen Bailey, private capacity, *Committee Hansard*, Sydney, 17 June 2011, p. 16.

113 Mr Colin Baldwin, Student Counsellor, Tasmanian Polytechnic, *Committee Hansard*, Hobart, 4 November 2011, p. 8.

114 Ms Coulter, CDU, *Committee Hansard*, Darwin, 17 October 2011, p. 1.

115 Ms Coulter, CDU, *Committee Hansard,* Darwin, 17 October 2011, p. 1; Miss A, Ex-client of OYH, *Committee Hansard*, Melbourne, 13 April 2011, p. 21; Ms Glover, Tasmanian Polytechnic, *Committee Hansard,* Hobart, 4 November 2011, p. 7.

2.131 Ms Edwina Grose, Director, Student Administration and Equity Services at CDU, summarised the point of her service as being to retain students:

> What we try and do in Equity Services is just make the whole rigid academic structure a little more flexible, and, hopefully that contributes to student retention.[116]

2.132 Ms Kerrie Coulter, Disability Liaison Officer at the Charles Darwin University, outlined her role as a spokesperson for students with a mental illness,

> We become the buffer between [the student and lecturer] ... the lecturers will refer students to us ... students have an access plan developed which talks about adjustments made for them that semester of their studies ... that is used to liaise with the lecturers. It also informs the lecturer of what their adjustments are so that they can then liaise with them without needing to depend on me.[117]

2.133 Ms Linda Glover, Disability Liaison Officer at the Tasmanian TAFE, provided examples of the types of modifications she had facilitated for students with a mental illness. She said one practical strategy employed for a student who was regularly half an hour late to early morning classes was to place a chair near the door for them to slip into the classroom unobtrusively, and for the lecturer to structure a bit of a recap of the lesson into the timetable for all students once that student arrived.[118]

2.134 In addition to negotiating adjustments for students, disability liaison support officers assist students with profound mental illness to withdraw from courses or to defer studies without incurring academic or financial penalties.[119]

There to help students with a mental illness too

2.135 Picking up on a point made earlier in the chapter by Ms Reece, not all disability liaison officers view themselves as being there to help students with a mental illness as much as students with a physical disability. The Psychosocial Research Centre stated the other side of the barrier, namely that students don't always see disability liaison officers as there to help them:

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116 Ms Edwina Grose, Director, Student Administration and Equity Services, CDU, *Committee Hansard,* Darwin, 17 October 2011, p. 3.

117 Ms Coulter, CDU, *Committee Hansard,* Darwin, 17 October 2011, p. 1.

118 Ms Glover, Tasmanian Polytechnic, *Committee Hansard,* Hobart, 4 November 2011, p. 7.

119 Ms Coulter, CDU, *Committee Hansard,* Darwin, 17 October 2011, p. 1.

> Students may not necessarily view their mental health related difficulties as fitting with notions of disability, yet accessing additional supports and adjustments to which they are entitled within educational settings typically depends upon identifying as having a 'disability'.[120]

2.136 Miss A concurred that students often do not realise that disability liaison officers assist people with a mental illness. She said that she only realised they might be able to offer her assistance when informed by Orygen Youth Health.[121]

2.137 By contrast, Mr Munro, a Vocational Education Training (VCE) student at the Charles Darwin University (CDU) said that the role of equity support had been well promoted there, in student outlines. He observed that perhaps support had also been forthcoming because he had self-identified as someone with a mental health issue when he first enrolled in the course.[122]

Mental health not just disability liaison officers' and student services' responsibility

2.138 The Committee recognises that disability liaison officers can have heavy workloads and many calls upon their time and expertise on campuses where demand from student populations is steady, if not increasing. It appears that most DLOs work together with counselling staff as part of a student services team but there is usually only one position dedicated to disability support. Traditionally disability liaison officers' role has been to help students with a physical disability and increasingly they are being called upon to assist students with mental illnesses.

2.139 Throughout the course of the inquiry it appeared that some disability liaison officers have more experience and expertise in mental health than others. While acknowledging that many DLOs come from extensive backgrounds in community and social work where mental health issues will have formed part of their case-loads and they may well be very experienced in this area, others coming from leisure studies and other fields may find themselves less well-qualified.

2.140 The Committee is of the view that all disability liaison officers should be equipped with the necessary skills and training to assist students with mental ill health, in some capacity, even if it is just recognising the symptoms and referring them on to specialist services, be it counsellors or

120 Psychosocial Research Centre, *Submission 33*, p. 2.

121 Miss A, Ex-client of OYH, *Committee Hansard*, Melbourne, 13 April 2011, p. 21.

122 Mr David Munro, Student, CDU, *Committee Hansard,* Darwin, 17 October 2011, p. 2.

clinicians. Disability liaison officers should also have access to ongoing professional development that aids them to respond effectively to students with mental ill health, and something beyond a one-off Mental Health First Aid course.

2.141 There may be a role for the Commonwealth to coordinate a national approach to ensure that all disability liaison officers receive the relevant professional training to assist students with mental ill health. This training should adhere to best practice and be consistent nationwide.

2.142 It may be appropriate to raise the profile of the student services available to students with mental health issues on campuses, including the role of the disability officer.

2.143 Nonetheless, the Committee is of the view that assisting students with mental illness and promoting the mental health of all students on campus is a responsibility that extends beyond disability liaison officers and the broader student services.

2.144 University and TAFE administrations, teaching staff and the wider educational community all have an important role to play in this regard, from setting the direction from the top and encouraging inclusivity to noticing early warning signs and encouraging students to seek help from professionals.

Recommendation 3

The Committee recommends that the Commonwealth Government work with peak bodies such as Universities Australia and TAFE Directors Australia to coordinate a national approach to ensure that teaching and other relevant staff at universities and vocational education institutions be educated about ways to support students with mental ill health, with access to staff professional development on mental health issues. Disability liaison officers and student services staff should be appropriately skilled to assist students with a mental illness and have access to ongoing professional development in this area.

Re-engagement with education, basic skills acquisition and the transition into work

2.145 In Whyalla, Mrs Marie Kuchel, Program Manager at UnitingCare Wesley Port Adelaide talked about her experience helping people back into education and work. According to her the biggest barrier is:

> A gap between basic education and TAFE which is stopping a lot of consumers we deal with going on any further into the workforce... We would have 70% of our consumers in our numeracy and literacy class...[123]

2.146 Many kids are leaving school without the basics:

> When mental ill health strikes, it generally will strike in teenage years or early adulthood. The signs of it are probably seen in schools, but it is not picked up on. Now there are lots of programs that are picking it up. But they all go through the school system rather than say there is a problem.[124]

2.147 Mrs Kuchel went on to describe how when consumers come onto their books, they may not have basic living and social skills:

> ... there is a gap between [what we can offer, basic education] and [them] being not quite ready for TAFE yet ... There is no way they

123 Mrs Marie Kuchel, UnitingCare Wesley Port Adelaide, *Committee Hansard*, Whyalla, 6 June 2011, p. 2.

124 Mrs Marie Kuchel, UnitingCare Wesley Port Adelaide, *Committee Hansard*, Whyalla, 6 June 2011, p. 2.

> are going to be able to go on to further education and/or work unless we get that middle section right.[125]

2.148 A range of programs exist to fill this gap. BoysTown referred to its Get Set for Work school to work transition program in south east Queensland.[126] The BoysTown website provided a little more information about the program for young school leavers aged 15 to 17 years who are unsure of their work futures:

> [It] provides a mix of practical activities focused on social skills, literacy and numeracy training, occupational skills and work-based learning to address learning and employment needs.[127]

2.149 Accredited training is delivered through a partnership with TAFE, Registered Training Organisations and the Aborginal and Torres Strait Islander Independent School.[128]

2.150 A respondent to the Australian Youth Forum consultation on mental health and workforce participation enthused about the BoysTown Get Set for Work program:

> BoysTown Get Set for Work programs in Queensland have had a great impact in getting youth who have had negative experiences of the formal education system back into training and employment through helping them see the value in themselves and their capabilities.[129]

2.151 Ms Glover described another initiative at the Tasmanian TAFE, specifically designed to help those people with a mental illness not yet ready to enrol in mainstream courses, to reengage with their community and learning pathways and to develop their skills.

2.152 Participants in the 'Exploring Options', Certificate I in Access to Work and Training Program, are referred from mental health practitioners, services and community organisations. The aim of the generalist course is to support people to gain skills in confidence, self-esteem and self-worth in a supported environment and 'sow seeds for pathways for further training'.[130]

2.153 Ms Glover pointed to the program's success by recounting one student's story. This student had been acutely unwell and spent an extended

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125 Mrs Marie Kuchel, UnitingCare Wesley Port Adelaide, *Committee Hansard*, Whyalla, 6 June 2011, p. 1.

126 BoysTown, *Submission 49*, p. 5.

127 BoysTown website, http://www.boystown.com.au/get-set-for-work.html

128 BoysTown website, http://www.boystown.com.au/get-set-for-work.html

129 Respondent in Australian Youth Forum, *Submission 73*, p. 22.

130 Ms Glover, Tasmanian Polytechnic, *Committee Hansard*, Hobart, 4 November 2011, p. 11.

amount of time in hospital, however throughout the course, they had began to regain confidence and rebuild their life:

> That person over time has become re-engaged with their family and re-engaged with social networks ... I understand that that student is studying at the University of Tasmania this year.[131]

2.154 Wodonga TAFE, which has higher than state average numbers of students with a disability, noted its range of general education preparation courses, including bridging options and short courses specifically designed for individuals with mental health issues.

> The Foundation Studies department has up to 90 enrolments per year into various course options for students with a psychiatric disability and each year this number continues to grow.[132]

2.155 The courses aim to improve language, literacy and work skills:

> They are designed to help gain the confidence needed to enter or re-enter education and/or the workforce.[133]

2.156 Wodonga TAFE referred to the diverse pathways that exist for course participants:

> Includ[ing] enrolment in further training options (including university) and part-time and full-time employment.[134]

2.157 Some criticism has been levelled at foundation training courses for being too generic – and not being tailored to the industry that consumers may wish to enter. The premise of this argument is that it acts as a further demotivator and adds to self-stigma.

2.158 Mrs Anthea Smith, Allied Health Manager, Employment Services, ORS Group described TAFE courses in NSW (specifically in the Liverpool area) that attempt to mitigate this. Some TAFEs offer courses such as a certificate I in retail or horticulture that are run specifically for clients with a mental health condition. She noted that these courses offer a more flexible service delivery model [than the mainstream courses in these areas] and are supported by a disability support worker.[135] However, Ms Smith added that 'That is definitely not something I have seen a lot of at every TAFE.'[136]

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131 Ms Glover, Tasmanian Polytechnic, *Committee Hansard*, Hobart, 4 November 2011, p. 11.

132 Wodonga TAFE, *Submission 7*, p. 1.

133 Wodonga TAFE website: http://www.wodongatafe.edu.au/organisation/about-us/teaching-departments/foundation-studies.aspx

134 Wodonga TAFE, *Submission 7*, p. 1.

135 Mrs Anthea Smith, National Allied Health Manager, Employment Services, The ORS Group, *Committee Hansard*, Gosford, 30 August 2011, p. 17.

136 Mrs Smith, The ORS Group, *Committee Hansard*, Gosford, 30 August 2011, p. 17.

Motivation

2.159 People suffering from mental ill health can lose motivation to pursue education, training or employment opportunities. Beyond the stigma often associated with mental ill health, a lack of motivation can be a side effect of the medication they are prescribed.[137]

2.160 Associate Professor Vicki Bitsika, Behaviour Management and Psychology, and Associate Dean for Teaching and Learning, Faculty of Humanities and Social Sciences, Bond University, indicated that prevocational training has been unsuccessful because it is too generic, and not tailored to the individual's needs and their employment goals.[138]

2.161 Mr Jeff Cheverton, Chief Executive Officer, Queensland Alliance for Mental Health raised another potential disincentive to participation in generic training when people are subject to 'endlessly training … for jobs that they never get'.[139]

2.162 Dr Geoffrey Waghorn warned that if a person is not sufficiently self-motivated, and in the right space, to study or get into employment, there is little point in directing resources to those ends:

> You cannot help people who do not want help...A better way to do it is to say, "You are eligible for this assistance, but it is most likely to work when you really want it."[140]

2.163 Other witnesses pointed to the time lags incurred in getting people the assistance they need and want. Orygen Youth Health referred to these as 'demotivation periods.'[141]

2.164 Ms Collister from Mental Illness Fellowship Victoria emphasised how important it was to intervene quickly and 'capture the moment somebody says they want to work':

> What happens is people lose their motivation and drive during periods [of generic prevocational training for example]...we have to act quickly...our approach is to find the right job for that person and match their skills and interests.[142]

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137 See for example Dr Geoffrey Waghorn, *Committee Hansard*, Brisbane, 9 August 2011, p. 14, VETE, *Submission 70*, p. 2, AYF, *Submission 73*,p. 8 Workskills, *Submission 34,* p. 3 and Mental Illness Fellowship Victoria, *Committee Hansard*, Melbourne, 13 April 2011, p. 2.

138 Associate Professor Vicki Bitsika, Behaviour Management and Psychology, and Associate Dean for Teaching and Learning, Faculty of Humanities and Social Sciences, Bond University, *Committee Hansard*, 8 August 2011, p. 7.

139 Mr Jeff Cheverton, Chief Executive Officer, Queensland Alliance for Mental Health, *Committee Hansard*, 9 August 2011, p. 18.

140 Dr Geoffrey Waghorn, *Committee Hansard*, Brisbane, 9 August 2011, p. 14.

141 Orygen Youth Health, *Submission 28*, p.3.

142 Ms Laura Collister, CEO, *Mental Illness Fellowship of Victoria,*

2.165 The key to the success of foundation courses, or indeed any course, is the desire and motivation of the student to complete the course and having the necessary supports around them to help them accomplish their goals. Some people may find it helpful to undertake a prevocational training course in order to build their confidence to go on to do other courses. For others, a too generic course may prove demotivating. For them, undertaking a more specialised training course, with either inbuilt supports such as those mentioned above, and/or access to the broader student support services on campuses, such as counselling and disability liaison officer support, are better approaches.

Peer supports/PHaMS

2.166 Mrs Kuchel from UnitingCare and others spoke to the level of ongoing support that some people with a mental illness may require once at TAFE as well as prior to commencement of their studies. She said:

> They can have a really bad day at TAFE, and straight away their confidence is right back where it started. If there could be somebody in place who could monitor them ... until they finish their course that would go a long way.[143]

2.167 Ms Reece said that if she had had access to something like the Personal Help and Mentoring Service (PHAMS) when she first went to university, that would have helped her enormously, to get through her studies.[144] She is now working towards re-entering university, with the support of her current PHAMS worker.[145]

2.168 Ms Reece spoke about the positive impact that the program had had on her whole life, not just helping her reengage with further education:

> It has given me a lot of confidence back. I have gained a lot of skills. I have a resume which looks a lot healthier than it did and spending time with people who think i have potential as well as limitations had made a really big difference.[146]

2.169 One of the especially pleasing aspects of the program is that many of the participants train in turn to become peer support workers themselves. Ms Reece told of how she had since trained as a peer support worker and

143 Mrs Kuchel, UnitingCare Wesley Port Adelaide, *Committee Hansard*, Whyalla, 6 June 2011, p. 1.

144 Ms Sarah Reece, *Submission 17.1*, p. 1.

145 Ms Sarah Reece, Participant, PHaMs West Program, *Committee Hansard,* Adelaide, 7 June 2011, p. 4.

146 Ms Sarah Reece, Participant, PHaMs West Program, *Committee Hansard,* Adelaide, 7 June 2011, p. 4.

been employed by MIFSA on a casual basis, something she described as 'wonderful'.[147]

2.170 PHaM is a Commonwealth program that runs nationwide. The program:

> provides access to early intervention support for people with persistent and/or episodic illness at crucial points in their lives to support recovery and reduce social isolation and a greater focus on employment outcomes.[148]

2.171 Ms Fiona Johnson, Team Leader, PHaMS West Program, responsible for six sites within South Australia, Mental Illness Fellowship of South Australia added:

> It is a non-clinical program, based on psychosocial rehabilitation, so the focus is really looking at the life areas for somebody where their mental illness is impacting. The majority of the program is looking at those individuals who slip between the cracks of the present mental health system. An individual does not need a diagnosis of a mental illness in order to access our support, which is wonderful. It means we capture people who may not present as sick enough or at danger.
>
> The focus is on long-term support for individuals. It is not time-limited, which means that our program worker and a participant can work on goals at a pace that suits the individual. The design is that they connect with services that are appropriate to the participant at the participant's request. The goal setting is focusing on life areas...such as communication, interpersonal skills, education, transportation, social and community activities, accommodation, domestic routines and clinical and self-care.
>
> We focus strongly on employment and what it means to become employed and maintain employment which the majority of our participants within the program, feel they would like to move into at some stage- and also what it means to actually goal-set towards that and to have maintainable goals that take into consideration self-care around their mental health.[149]

2.172 The program is being expanded:

> An additional 3, 400 people with severe mental illness will be assisted through the engagement by community organisations of

147 Ms Sarah Reece, Participant, PHaMs West Program, *Committee Hansard,* Adelaide, 7 June 2011, p. 4.

148 Joint department Submission 62, p. 16.

149 Ms Fiona Johnson, Team Leader, PHaMs West Program, Mental Illness Fellowship of South Australia, *Committee Hansard*, 7 June 2011, p. 2.

> 425 new personal helpers and mentors to provide practical, one-on-one support for people with severe mental illness to set and achieve personal goals such as finding employment, improving relationships with family and friends, and manage everyday tasks such as using public transport or housekeeping.
>
> As part of this expansion, up to 1, 200 people with mental illness on, or claiming income support, on the DSP who are referred to employment services will also have access to PHaMS services. This service will help people with a mental illness stay engaged with employment services while they look for work, or participate in work and training.[150]

2.173 The joint department Submission provides case-studies of people with a mental health condition being encouraged and supported by their PHaMS worker to commence and complete studies. The examples illustrate how work opportunities can be successfully cultivated alongside further education:

> Andy*...with the help of the PHaMS worker he received a full scholarship to study graphic design...Andy now goes to school, has his own place to live and has been promoted at work [he got a job in a pub working 30 hours per week and has come off the DSP]...
>
> Jenny*...As her 'wellness' improved the PHaMS team were able to support her in a medication reduction regime and identify some goals. These included returning to work...She also enrolled in additional tertiary education and found school exhilarating and began to blossom. At this point the PHaMS program was developing its Peer Support Worker Program that included 13 weeks of 'on-the-job' training. Jenny is now a paid employee working three days a week...and is encouraging the PHaMs service to develop this opportunity for other participants.[151]

2.174 Several witnesses praised the ethos of FaHCSIA's PHAMS model[152], which is supporting people with a mental illness to reengage with the community.

2.175 Mr Evan Lewis, Group Manager, Disability and Carers, FaHCSIA talked about how the PHaMs program had evolved from its initial premise of

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150 Joint department Submission 62, pp. 16-17.

151 Joint department Submission 62, pp. 23-24.

152 See website for details: http://www.fahcsia.gov.au/sa/mentalhealth/progserv/PersonalHelpersMentorsProgram/Pages/default.aspx#1

social connection, to help people with a mental illness undertake studies and find work:

> PHamS was not initially intended to be an employment service. It was more about social initially, but we have found that we are getting people who, with better medication nowadays, could be stabilised, could graduate...from our program and go to work. We now have a chunk of money. We have spent a lot of time before the announcement with DEEWR and DoHA talking about how that would work with employment services in thinking about the people who, with some assistance, are involved in the DSP system and who are potentially able to be employed that we can do something different for.[153]

2.176 The Royal Australian and New Zealand College of Psychiatrists state that education and training programs need to incorporate support measures for students with psychiatric disorders and that the use of trained peer support should be deployed to overcome the stress and difficulties their condition may place on study.[154]

2.177 The College of Psychiatrists refers to New Zealand's Like Minds organisation and their development of an Individual Placement and Support program called the Sentinel Project which is aimed at supporting tertiary students with a mental illness:

> It is hoped that peer led recovery learning (support provided by others who have come through mental illness) plus service user leaders will be identified and trained to support students. The aim would be to put in place work plans, study schedules and mentors within tertiary education organisations.[155]

2.178 Ms Reece indicated that a social support group comprised of her peers would have been extremely beneficial to her throughout her time at university:

> ... something on campus – a group for people with mental illnesses trying to study at tertiary level ... [and] some assistance to [link] up to social support would have been enormously helpful.[156]

2.179 A respondent to the Australian Youth Forum also referred to the importance of peer support, and:

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153 Mr Evan Lewis, Group Manager, Disability and Carers, FAHCSIA, *Committee Hansard*, 14 October 2011, p. 5.

154 Royal Australian and New Zealand College of Psychiatrists, *Submission 39*, pp. 8-9.

155 Royal Australian and New Zealand College of Psychiatrists, *Submission 39*, p. 8.

156 Ms Reece, Participant, PHaMs West Program, *Committee Hansard*, Adelaide, 7 June 2011, p. 7.

> Having a place to go and hang out with a small group of people like a student services room.[157]

2.180 Having a program, such as the one in New Zealand, operating in Australian universities could complement the services offered by disability liaison officers and other support staff, as well as those offered by PHAMS. Especially given that there is usually only one disability liaison officer at each university or TAFE and therefore only limited support that can be provided to each student.

2.181 The Committee watches with interest the development of the New Zealand Sentinel Project.

2.182 At the same time, the Committee recognises that general and specific peer mentoring programs are already a successful feature of many Australian university campuses. For instance, the University of New South Wales offers a peer mentoring program:

> Peer mentors are experienced students who provide support to new students making the transition to university...can help make the transition to uni life as smoothly as possible, by providing support, opportunities to meet new people and benefit from the experiences of other students.[158]

2.183 Apart from being available to first year students, there are specific programs for international students, students coming from rural/interstate locations, mature-aged students and students transferring from other educational institutions.

2.184 Students' feedback on these sorts of programs is positive and the benefits for their well-being myriad:

> "I really enjoyed my mentoring sessions. The mentors have been able to answer any questions...and given me support and guidance to adjust to university life."
>
> "As I was part of a mentoring group for mature age students, it helped me get to know a few people in similar situations, talk about things they've done, which in turn helped me and made me feel a little less alone..."[159]
>
> "I had a really excellent experience. My mentor helped me through."[160]

157 Respondent, Australian Youth Forum, *Submission 73*, p. 21.

158 University of New South Wales website, http://studentlife.unsw.edu.au/services/peer-mentoring/

159 University of New South Wales website, http://studentlife.unsw.edu.au/services/peer-mentoring/

160 Matt Wilkenson, in *The Sydney Morning Herald*, 8 February 2011, p. 12.

Recommendation 4

The Committee recommends that the Commonwealth Government encourage more peer support programs on Australian university and TAFE campuses, including those that specifically support students with a mental illness.

Transitioning into the workforce

2.185 The National Disability Coordination Officer (NDCO) Program exists to:

- improve transitions to help people with a disability move from school or the community into post-school education and training and subsequent employment;
- increase participation by people with disability in higher education, vocational education and training and employment;
- establish better links between schools, universities, TAFES, training providers and disability service providers so that they can work together to provide the best possible assistance for people with a disability.[161]

2.186 The Mental Health Council of Tasmania referred to a key initiative of the National Disability Coordination Officer Program, a resource titled 'Mountain climbing', prepared in Tasmania but designed to help tertiary graduates nation-wide with a lived experience of mental illness transition to employment on completion of their studies.[162]

2.187 The 'Mountain Climbing' resource aims to:

> Give you some of the equipment you might need to make a smooth transition into work. It's also designed to help you get through the first week of work and to stay employed once you get a job.[163]

161 The National Disability Coordination Officer (NDCO) website, http://www.deewr.gov.au/Skills/Programs/Support/NDCO/Pages/default.aspx

162 Mental Health Council of Tasmania, *Submission 18,* p.2.

163 Mountain Climbing: A resource for tertiary graduates with lived experience of mental illness making the transition to employment, http://www.ndcotas.com.au/assets/files/UGRO3542_Mental%20Health%20booklet_Electronic.pdf, p. 7.

2.188 Throughout the informative 80-page booklet, many myths are countered. For instance, that it is better for someone with a mental illness to feel fully well before working or looking for work. In fact, the opposite is true:

> Working and looking for work keep you engaged and can actually speed up the recovery process.[164]

2.189 Similarly, there is a myth that people with a mental illness are less productive than other employees, or should only work at low stress jobs that require no interpersonal conduct. Contrary to this stereotype, the resource tells graduates that:

> People with a mental illness can perform high stress jobs if they have a high stress tolerance, learn effective coping mechanisms and manage their illness well. Interpersonal contact at work can have restorative effects for people with a lived experience of mental illness.[165]

2.190 Another key feature of the booklet, and probably its greatest strength, is the use of stories from university and TAFE graduates with a lived experience of mental illness, recounting how they have personally and practicably dealt with issues like disclosure, stigma and prejudice in a range of workplaces.

2.191 The pros and cons of disclosure are examined in some detail. Some people, it seems, choose to disclose straight away, others partially disclose or disclose further into their employment once established in their position. Others choose not to disclose at all. Both bad and good experiences are highlighted but ultimately graduates are empowered with the message that:

> It's up to you if you want to tell your employer about your condition [and how you go about doing so].[166]

2.192 The booklet also addresses one of the other main concerns that some people with a mental illness have, about whether to take on full-time or

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164 Mountain Climbing: A resource for tertiary graduates with lived experience of mental illness making the transition to employment, http://www.ndcotas.com.au/assets/files/UGRO3542_Mental%20Health%20booklet_Electronic.pdf, p. 6.

165 Mountain Climbing: A resource for tertiary graduates with lived experience of mental illness making the transition to employment, http://www.ndcotas.com.au/assets/files/UGRO3542_Mental%20Health%20booklet_Electronic.pdf, p. 35.

166 Mountain Climbing: A resource for tertiary graduates with lived experience of mental illness making the transition to employment, http://www.ndcotas.com.au/assets/files/UGRO3542_Mental%20Health%20booklet_Electronic.pdf, p. 55.

part-time employment, and strategies for negotiating flexibility on their hours with employers, including taking on more work once settled.

2.193 The case-study model attests to the usefulness of graduates building themselves support networks, be it utilising the careers service at university or TAFE and/or external health professionals and employment agencies.

2.194 Useful, practical tips on how to stay well appear throughout the resource as well. Further to this, the booklet contains information on a host of organisations from whom additional support can be sought if required, for example, Mental Illness Fellowship and Bipolar.

2.195 There is a section on Centrelink payments and how to apply for income support in between graduating and finding a job, and what employment service providers, including speciality employment service providers, can offer, and how to access their services.

2.196 At the same time, there is an emphasis on the standard job search process and busting the myth that most people with a mental illness always need specialised disability resources to get a job. In fact:

> Most people with a mental illness get jobs on their own or with standard job search assistance.[167]

2.197 The booklet is characterised by positive and encouraging language and reinforcement throughout of the graduates' strengths, reminding them of the suite of skills and abilities they bring to bear having already successfully completed their studies.

2.198 The resource concludes with some basic information on how to access the Jobs in Jeopardy program, if that is an appropriate option for graduates who find themselves in a job that is not working out, a bibliography and website URLS for a host of helpful organisations like Beyond Blue and SANE Australia.

2.199 In the end, the key to success for graduates with a mental illness finding and keeping a job is the same as for any graduate:

> Success factors for people with a mental illness in employment do not necessarily relate to their skill levels or their type of mental illness but their work history and experience, their motivation to

167 Mountain Climbing: A resource for tertiary graduates with lived experience of mental illness making the transition to employment, http://www.ndcotas.com.au/assets/files/UGRO3542_Mental%20Health%20booklet_Electronic.pdf, p. 47.

> work, their social skills and the quality and duration of the employment and mental health supports they receive.[168]

2.200 The Mountain Climbing resource is a useful one for university graduates. It would be good to see something similar prepared to assist people who complete vocational education and training courses.

168 Mountain Climbing: A resource for tertiary graduates with lived experience of mental illness making the transition to employment, http://www.ndcotas.com.au/assets/files/UGRO3542_Mental%20Health%20booklet_Electronic.pdf, p. 73.

3

Employers, employees and workplaces

> The broader diversity in participation and skill shortages is what will sell [employing or retaining an employee with a mental illness] to the employer.[1]
>
> Employers could be missing out on potentially valuable employees through misconceptions and stereotypes of people with a mental illness.[2]
>
> Everybody is potentially one major life crisis away from becoming quite unwell. All employees are a bit of a risk and everybody with a mental illness has potentially, with the right support and a good network, a way of getting everything back on track and being able to be a contributing member of society in that respect.[3]

3.1 Some of the major barriers to participation in employment for people with a mental health condition include stigma, fear and ignorance amongst employers and co-workers, and inflexible and inappropriate working arrangements.

3.2 Many witnesses reflected on the need for employers to be more receptive to and supportive of employing and retaining employees with a mental health condition by offering flexible working arrangements. They argued this can be achieved through greater education to counter negative

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1 Ms Jennifer Lambert, Director, Education and Training, Australian Chamber of Commerce and Industry, *Committee Hansard,* 14 October 2011, Canberra, p. 45.

2 Mr Dale Campbell, CEO, TopEnd Association for Mental Health, TEAMHealth, *Committee Hansard*, 17 October 2011, p. 19.

3 Ms Sarah Reece, PHAMS participant, *Committee Hansard*, 7 June 2011, Adelaide, p. 8.

stereotypes, incentives and access to other appropriate supports and services, on an as-required basis.[4] Beyondblue stated:

> There is a lot of misconceptions out there about mental health problems and understanding of people's ability to undertake employment, so employers and managers often do not know what to do. They just do not have the practical strategies necessary to know how to support someone who is experiencing difficulties.[5]

3.3 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health emphasised the need to tackle stigma in workplaces and stated that governments should support this endeavour. He spoke of the need to overturn commonly held assumptions by employees that having someone with a mental illness at their workplace would entail more work for them. He indicated this is hardly ever the case and that a person with a mental illness will work just as well, if not better than a person without a mental illness, especially if they are getting good treatment for their illness and the workplace is adequately prepared to deal with any issues should they become unwell.[6]

3.4 Moreover, businesses and organisations need to promote mental health, wellbeing and resilience as essential components of a healthy workplace and workforce.[7] This is the responsibility of both employers and employees.

3.5 While the Committee heard much from the supply side of the employment equation (people with mental ill health and employment service providers) about what employers might do better, they heard fewer first-hand accounts from the demand side (the employers). However, the demand side of the equation is of primary importance to achieving participation. What employers think about employing or retaining staff with mental health conditions, what is being and can be done to utilise this resource, and what additional supports, if any, employers think they require provides a focus for this chapter.

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4 See for example, Beyondblue, *Submission 21*, p. 6, Lantern, *Submission 22*, p. 4, Australian Human Rights Commission, Submission 44, pp. 2-3 and Anglicare Tasmania, *Submission 69*, p. 9.

5 Ms Therese Fitzpatrick, National Workplace Program Manager, Beyondblue, *Committee Hansard*, 19 August 2011, Melbourne, p. 2.

6 Dr Aaron Groves, Queensland Health, *Committee Hansard*, 9 August 2011, p. 5.

7 See for example Black Dog Institute, *Submission 16*, p. 3, The Australian Psychological Society, *Submission 40*, p. 14, and Mates In Construction, *Submission 60*, p.3.

Productivity and inclusivity benefits of increased participation

3.6 Chapter one referred to the need to redress an ageing workforce and remedy workforce shortages in Australia, especially to service the growing resources sector.

3.7 On workforce shortages, Mr Stephen Bolton, Senior Advisor, Employment, Education and Training, ACCI observed:

> Despite some of the economic doom and gloom that is affecting some sectors of the economy at the moment, there are still pockets of fairly significant skills and even labour shortages out there at the moment. Enhancing workforce participation is going to be one of the great challenges over the next 10-15 years if we are to meet the full gamut of work that is in the pipeline, especially in the resources sector, and across the broader industry as we move into economic recovery.[8]

3.8 Mr Bolton added that keeping good staff is a priority:

> ...the costs associated with re-employment are enormous... unemployment levels are so low, people want to hold on to good staff. They...are much more aware of things that can be done within their workplace environment that will keep good people at work while also welcoming more good people who may be living with a disabling illness.[9]

3.9 Plotting a path between the need to find more skilled labour and a willing cohort of people wanting to enter the workforce requires learning more from employers about how to best match the interests of both groups.

3.10 Given the workforce shortages and a commensurate need for creative solutions to fill them, it was disappointing to not receive more evidence from employer associations and employers. However, the Committee is grateful for the evidence it received from the following employer associations and companies: the Australian Chamber of Commerce and Industry (ACCI); Chamber of Commerce and Industry of Western Australia (CCI WA); Abigroup Construction, Rio Tinto and Dampier Salt.

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8 Mr Stephen Bolton, Senior Advisor, Employment, Education and Training, Australian Chamber of Commerce and Industry, *Committee Hansard*, 14 October 2011, Canberra, p. 43.

9 Ms Barbara Hocking, CEO, SANE Australia, *Committee Hansard*, 13 April 2011, Melbourne, pp. 28-29.

3.11 ACCI acknowledged upfront that the economic case for greater participation of people with a disability is strong but noted that it is imperative to develop 'a business case on the productivity and workforce benefits of increasing participation.'[10]

3.12 ACCI said that it is not that employers need convincing about the importance of a total participation and diversity agenda per se, rather 'how to get proper engagement' and traction on the issue, at the same time as recognising that:

> At the end of the day it is the productivity, profitability and sustainability of businesses that allows the investment in equity issues.[11]

3.13 Further, it may more useful to consider mental health as a subset of a broader inclusivity approach:

> Encouraging a culture of open-mindedness, encouraging a culture of understanding or greater awareness, and most importantly, encouraging the proper networking between the supply and the demand side.[12]

Concerns about employees' reduced productivity

3.14 ACCI cited concerns that employers may have about the reduced productivity of employees with a mental health condition:

> Having mental health issues can effect productivity in the workforce and it can have an adverse effect on motivation and your engagement in the workforce. You become more inclined to absenteeism and drop out; then once you are out of the workforce that is then compounded by some of the esteem issues that are related to not being in the workforce, and so it then spirals down in ever-diminishing circles, until you, effectively, totally disengage from the workforce.[13]

10 Ms Jennifer Lambert, Director, Employment, Education and Training, ACCI, *Submission 71*, p. 1.

11 Ms Jennifer Lambert, Director, Employment, Education and Training, Australian Chamber of Commerce and Industry, *Committee Hansard*, 14 October 2011, Canberra, p. 41.

12 Ms Jennifer Lambert, Director, Employment, Education and Training, Australian Chamber of Commerce and Industry, *Committee Hansard*, 14 October 2011, Canberra, pp. 41-42.

13 Mr Stephen Bolton, Senior Advisor, Employment Education and Training, Australian Chamber of Commerce and Industry, *Committee Hansard*, 14 October 2011, Canberra, p. 43.

3.15 CCI WA concurred and suggested that employers, especially small business employers, may worry about the reliability of employees with a mental health condition.[14]

3.16 It should be noted that the perception or stereotype of someone with a mental health condition as being less productive or more unpredictable in their behaviour exists in the broader community, not just workplaces.

3.17 SANE Australia and other witnesses indicated that every workplace has someone with a mental illness, and that many cases are simply not disclosed. SANE Australia refuted the stereotype that:

> ...everyone with a mental illness is very severely disabled and unable to work. That is very, very far from the truth.[15]

3.18 Ms Bernette Redwood, Executive Officer, Vista Vocational Services said that another misnomer is that people with a mental illness are permanently unwell. She referenced her own illness and periods of being unwell, at the same time as noting that she had held management positions for 20 years.[16]

3.19 The Australian Human Rights Commission referred to an Australian Safety and Compensation Council (now Safe Work Australia) review that found that employees with a disability, including those with mental ill health, were no riskier than other employers. In fact, the contrary was true 'Employees with disability have lower number of OHS incidents and lower workers' compensation costs.'[17]

3.20 Ms Sarah Reece, Participant, PHaMs West Program, cautioned against making assumptions and typecasting employees with a mental illness:

> I guess to a certain extent, from my perspective, a person without a diagnosis of mental illness is not necessarily any less at risk of becoming unwell or having a major life crisis. I do not really see myself as being at high risk. Considering that I have lived with my particular conditions for a long time and I have demonstrated an excellent ability to manage them, I look at my situation and go "I am lower risk". I have come through major life crises. I have been homeless, I have experienced domestic violence. I have come

14 Ms Marcia Kuhne, Manager of Industrial Relations Policy, Chamber of Commerce and Industry of Western Australia, *Committee Hansard*, 18 October 2011, Perth, p. 3.

15 Ms Barbara Hocking, CEO, SANE Australia, *Committee Hansard*, 13 April 2011, Melbourne, p. 23.

16 Ms Bernette Redwood, Executive Officer, *Committee Hansard*, 13 May 2011, Canberra, p. 14.

17 AHRC, *Submission 44*, p. 4.

> through all sorts of stuff, I am still here. That means I have some pretty good skills at managing my stuff...[18]

3.21 Ms Jennifer Lambert, Director, Employment, Education and Training, ACCI stated that there needs to be a broader picture of success to mitigate against negative attitudes and stereotypes about people with a mental illness in the workforce:

> We need to have a broader amount of knowledge. We have participation statistics, numbers on disability support pensions, the types of disabilities and mental health issues out there, but we actually do not have a picture of where success happens. We only have a limited case-study picture of where success happens.[19]
>
> Government invests a great deal of money in disability service providers but yet most employers are not aware of DES, nor is the employment of people with mental health a mainstream issue.[20]

Social enterprises versus open employment

> A social enterprise is a not-for-profit business venture that trades for a social purpose...A social firm is one type of social enterprise and has the employment of people with a mental illness or disability as its purpose. Any modifications required for the employee in need of support are built into the design of the workplace.[21]

3.22 There are two types of social firms. The first type employs people in a long term capacity and the second operates more as a transitional employment experience whereby employees gain skills for entry into the open workforce. The Commonwealth contributes funding to both kinds of social firms.

3.23 Essentially, social firms are supportive work environments that:

- employ between 25% and 50% of employees with a mental illness or disability;
- pay all workers at award/productivity based rates;

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18 Ms Sarah Reece, Participant, PHaMs West Program, *Committee Hansard*, 7 June 2011, Adelaide, p. 8.

19 Ms Jennifer Lambert, Director, Employment, Education and Training, Australian Chamber of Commerce and Industry, *Committee Hansard*, 14 October 2011, Canberra, p. 45.

20 Ms Jennifer Lambert, Director, Employment, Education and Training, ACCI, *Submission 71*, p. 2.

21 Social Firms Australia, *Submission 38*, p. 1.

- provide the same work opportunities, rights and obligations to all employees; [and]
- generate the majority of … income through the commercial activity of the business although grants and subsidies may be needed to be used to off-set loss of productivity.[22]

3.24 Traditionally, social enterprises have focused on the services industry. Ms Caroline Crosse, Executive Director, Social Firms Australia (SoFA) said:

> The social firms that we have established, or have supported the establishment of, so far are in the more labour intensive types of business that are easier to start up- cleaning, maintenance, recycling, a nursery, a cafe...[23]

3.25 Other witnesses referred to similar businesses. Ms Bernette Redwood, Executive Officer, Vista Vocational Services spoke to the successes they have in placing work-ready clients (who are stable on their medication) in their horticulture business and Cafe Pazzini in the ACT[24]. WISE Employment referred to social enterprises they operate in Victoria and Tasmania, including cleaning and maintenance services.[25]

3.26 SoFA referred to the evolution of social enterprises and their own expansion plans for the future:

> Five e-waste social firms will be launched later this year and a couple of organisations are looking at buying businesses, and we are looking at hotels or maybe a supermarket. [26]

3.27 SoFA added that the new Commonwealth Social Enterprise Development and Investment Fund (SEDIF) is a welcome addition to government funding.[27]

3.28 The $4 million SEDIF does not disburse grants but rather, 'provides flexible, tailored financial products and support to social enterprises'. Run by fund managers, Foresters Community Finance and Social Enterprise Finance Australia, the intention is to attract further investors into the

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22 Social Firms Australia, *Submission 38*, p. 1.

23 Ms Caroline Crosse, Executive Director, Social Firms Australia, *Committee Hansard*, 19 August 2011, p. 24

24 Ms Bernette Redwood, Executive Officer, Vista Vocational Services, Committee Hansard, 13 May 2011, p. 15 and 16.

25 Mr Richard Kane, Policy Advisor, WISE Employment, *Committee Hansard*, 4 November 2011, p. 34.

26 Ms Caroline Crosse, Executive Director, Social Firms Australia, *Committee Hansard*, 19 August 2011, p. 31.

27 Ms Caroline Crosse, Executive Director, *Committee Hansard*, Melbourne, 19 August 2011, p. 27.

funds to increase the pool of capital and support available to social enterprises.[28]

3.29 In practice this might mean:

- flexible financing to extend the operations of a restaurant training young people so it can take on more trainees, open another site or develop a catering business thereby increasing training and employment opportunities; or
- a loan to purchase or grow the operations of business which employs people with disabilities or mental illness.[29]

3.30 The Committee visited a number of social enterprises during the course of the inquiry. These included Outlook Environmental, which runs innovative state of the art waste transfer sites at Mornington, Knox, Hampton Park, Hume and Reservoir in Victoria; [30] the Madcap cafe in Dandenong and the Central Coast Laundry in Gosford.

Madcap cafe – a transitional employment model

'I used to exist, now I've got a life' – John

'I am a taxpayer again and I'm very proud of that. I'm well enough to be a good worker at Ermha (Eastern Regions Mental Health Association) and Madcap cafe and now Gloria Jeans.' –Diana

3.31 The MadCap project has been a recipient of Innovation Fund funding, a federal government grants program that fosters innovative solutions to overcoming the multiple barriers that can often be faced by the most disadvantaged job seekers, including people with a mental illness. Mad cap aims to develop a not-for-profit franchising model which can be replicated across Australia.[31]

3.32 The Committee visited an established Madcap Cafe site in the Westfield Fountain Gates Shopping Centre in Dandenong, Victoria. Of all the social enterprises it visited, the Committee was perhaps most struck by the

28 DEEWR website, http://www.deewr.gov.au/Employment/Programs/SocialInnovation/SocialEnterprise/Pages/SEDIFFAQs.aspx viewed 23 February 2012.

29 DEEWR website, http://www.deewr.gov.au/Employment/Programs/SocialInnovation/SocialEnterprise/Pages/SEDIFFAQs.aspx viewed 23 February 2012.

30 See 'Effective solutions for a sustainable existence', Outlook environmental brochure and Outlook Environmental and Outlook websites for more details http://outlookenviro.org.au/ and http://www.outlookvic.org.au/

31 DEEWR, FahCSIA and DoHA, *Submission 62*, pp. 28-29.

Madcap cafe model, for the benefits it had conferred on participants and because of its focus on transitioning participants into open employment.

3.33 At the Madcap cafe in Dandenong workers told their personal stories and spoke to how the program had, quite powerfully, changed their lives for the better. These changes included markedly improved self-esteem, confidence and physical health, improved financial situations and improved relationships and social networks.

3.34 John relayed how he had started with Ermha seven years ago, after having been out of work for 20 years. Prior to his time at Ermha, he had weighed 150 kilograms, was a smoker and worried about losing his disability pension should he venture into employment and have it not work out. He described how in his time with Ermha he had built confidence as an employee and person. He said that he had lost a considerable amount of weight and stopped smoking. He had also recently completed a half marathon and saved for his first car.[32]

3.35 Madcap is an Ermha Initiative,[33] supported by DEEWR and other partners, that provides work opportunities for people with mental health conditions, who live in and around the City of Greater Dandenong and the shires of Casey and Cardinia in Victoria.[34]

3.36 The website describes how the Madcap transitional employment traineeship works in practice:

> The starting point for Madcap participants is the Aspirations Day Program. This program specialises in group work, social, recreational and vocational focused activities (this may take weeks or months...all training is self paced and tailored to the individual).
>
> Then comes the Barista Training program (a 4-day accredited course in Dandenong) and work at a MadCap Café for six months.
>
> Having gained the skills and confidence at Aspirations, the Barista Training and MadCap, participants are supported and encouraged to branch out and seek work in the wider community.[35]

3.37 At all stages, a support worker helps participants manage transition points, so called because they are recognised as times at which problems

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32 Site inspection, Madcap cafe, Fountain Gate shopping Centre, Melbourne, 12 April 2011.

33 Ermha is a community based organisation that supports recovery and instils hope for people recovering from experiencing the effects of a severe mental illness. For more details see the Ermha website: http://www.ermha.org/

34 Madcap cafe website, http://madcapcafe.org/

35 Madcap website, http://madcapcafe.org/

might occur. At the completion of their training Madcap works with trainees to help them secure jobs in the open marketplace by linking them with Job Services Australia (JSA) or Disability Employment Service (DES) for job placements.[36]

3.38 Beyond providing jobs, MadCap aims to improve the mental health of its participants by:

> Providing people with opportunities to participate in supportive networks while engaging in meaningful, skill and confidence building activities....The Madcap Venture seeks to ensure that people with mental health problems have the same opportunities for participation [and social inclusion] as everybody else. [37]

3.39 Interestingly, Madcap's approach to workplace modifications is to 'avoid accommodating the illness as much as possible'. This means:

> Us[ing] modern cognitive behaviour therapy methods to provide challenges that are designed to be achievable but that also ask the trainees to "take the next step" ... This might mean encouraging a trainee to complete a shift when they would rather leave [by pointing out the consequences of that action for themselves and the business].[38]

3.40 The program also works to demystify and destigmatise mental illness in the community:

> Macdcap wants to help reframe stereotypes about mental illness that are deeply entrenched in our culture. A mental illness can mask a person's abilities but those abilities still exist.
>
> A mental illness can be persistent but that does not mean it is necessarily intractable.
>
> A mental illness is an individual condition and each person with a mental illness will experience it in his or her own way.[39]

3.41 As part of its broader strategy to reframe the stereotypes about people with a mental ill health, the Madcap cafe is intentionally located in the 'economic heartland of busy shopping malls.'

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36 Madcap/Ermha, 'Madcap Enterprises exists to achieve one goal – to exist people with a mental illness who want to enter the workforce', *Exhibit 9*, p. 8.

37 Madcap cafe website, http://madcapcafe.org/

38 Madcap/Ermha document, 'Madcap Enterprises exists to achieve one goal – to exist people with a mental illness who want to enter the workforce', *Exhibit 9*, p. 8

39 Madcap/Ermha document, 'Madcap Enterprises exists to achieve one goal – to exist people with a mental illness who want to enter the workforce', *Exhibit 9*, p. 6.

> We create contemporary feel-good arenas, with great food, beverages and service, which not only drives business to our cafe (and Madcap cafes are first and foremost businesses competing with many other businesses for the public's food and beverage dollar) but also puts mental illness in a new light. The result is a message that tells our trainees that they are valued, shows our customers that mental illness is not so scary, and ultimately becomes the antidote to negative headlines about people with a mental illness.[40]

Benefits of social enterprises

3.42 As well as the many social benefits of social enterprises, Madcap points to the financial gains, not just for the individuals employed, but also for taxpayers. This is because the Madcap concept is focused on getting participants off the DSP and into mainstream employment. Madcap claims it is saving the government some $6 million over 10 years by employing 80 people at 15 hours per annum and 20 people at 30 hours per annum.[41]

3.43 Peter Waters, CEO of Ermha indicated that 116 participants had found short term jobs and 118 found long term jobs during a two year period of Jobs Fund funding.[42]

3.44 A number of witnesses spoke to the benefits of social firms. Boystown cited various research findings to support their view that:

> ...intermediate labour market programs such as social enterprises are an effective intervention that both builds the resilience of young people and promotes their social inclusion, particularly their participation in mainstream employment.[43]

3.45 Similar to Madcap's ethos of employment and support for program participants, Boystown's social enterprises provide employment at the same time as they provide wraparound support for young people.[44]

Argument for open employment

3.46 Other witnesses offered qualified support for social firms as 'the answer', recognising them as playing a role but also potentially perpetuating a

40 Madcap/Ermha document, 'Madcap Enterprises exists to achieve one goal – to exist people with a mental illness who want to enter the workforce', *Exhibit 9*, p. 7.

41 Madcap website, http://madcapcafe.org/madcaphelps.html

42 Email communication from Peter Waters, CEO, Ermha, 23 February 2012.

43 Boystown, *Submission 49*, p. 19.

44 Ms Tracy Adams, CEO, Boystown, *Committee Hansard*, Brisbane, 9 August 2011, p. 30.

stereotype that people with mental ill health need special treatment and cannot undertake open employment.

3.47 Ms Laura Collister, General Manager, Rehabilitation Services, Mental Illness Fellowship Victoria, acknowledged the confidence and opportunities that people with a mental illness can gain from employment in social firms. She said that Mental Illness Fellowship Victoria has its own social firm which it uses to help particular individuals transition to open employment. However, her view is that people with a mental illness should be working in the general community to counter stigma and effect change on a larger scale:

> I personally believe that the answer here is to find people with mental illness employment in the open employment market – that is a community responsibility, a community response. There is a danger with niche solutions because programs can become isolated from the general community rather than demonstrating that people with a mental illness are more like us than not like us, that they are capable of working. If we want to address stigma I think they should be working in the open community.
>
> ...open employment in the community is a large-scale change...if you find the right job for the individual, you have got to go to the community, where there are a million jobs, not a couple of social firms.[45]

3.48 Orygen Youth Health agreed:

> While [social firms] do provide an employment option, they are not part of the open labour market, which is where most experts agree the most sustainable jobs exist.[46]

3.49 The Committee affirms the function of social firms in supporting people with mental ill health, especially those who have been excluded from employment and mainstream society for a number of years, helping them to build the skills and confidence to go forward. The combination of employment and good support services are mutually reinforcing.

3.50 Nonetheless, open employment should be the goal. This is something often espoused by social firms themselves and not inconsistent when they function at their most effective by providing employees with the social and work skills required for transitioning to participation in the open employment market.

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45 Ms Laura Collister, CEO, SANE Australia, *Committee Hansard*, 13 April 2011, Melbourne, p. 11.

46 Orygen Youth Health Research Centre, *Submission 28*, p. 5.

Recommendation 5

The Committee recommends that the Commonwealth Government examine ways to further support social enterprises that effectively transition people with mental ill health into the open employment market.

Wage subsidies as incentives

3.51 Wage subsidies are:

> Payments made to eligible employers to help cover the costs of paying wages in the first few months of employment for a person with disability or a person experiencing other barriers to employment.
>
> There are a number of wage subsidy programs which are normally organised by Australian Government employment service providers. [47]

3.52 The DEEWR website explains how the scheme works:

> Disability Employment Services may negotiate to pay an employer up to $1500 (excluding GST) as an incentive to employ a participant.
>
> The employment must be for at least eight hours per week for at least 13 weeks and have a reasonable expectation of continuing for more than 13 weeks (or six weeks in a seasonal industry).
>
> The employment must be under open employment conditions. That is, under a legal industrial agreement that complies with minimum standards established under Commonwealth, state or territory law). It must also guarantee the worker a weekly award-based wage, for example: no commission based or subcontracting type positions.[48]

3.53 The Chamber of Commerce and Industry of Western Australia (CCI WA) suggested that wage subsidies can play a role in encouraging employers to employ someone with a disability, including people with a mental illness:

47 Australian Government Jobs Access website, http://jobaccess.gov.au/Jobseekers/Help_available/Financial_help_and_wage_information/Pages/Wage_subsidies.aspx

48 DEEWR website, http://www.deewr.gov.au/Employment/Programs/DES/Employer_Support/Pages/TheWSS.aspx

> Wage subsidies provided to employers will help to encourage recruitment and retention.
>
> [small businesses] might be more likely to employ someone who manifests those problems if they were able to access some sort of wage subsidy.[49]

3.54 The Top End Association for Mental Health commented that subsidies can be a way to start a consumer's journey towards mainstream employment.[50]

3.55 DEEWR said that wage subsidies are important and referred to them as catalysts:

> Often it is the first time someone has taken on somebody with a disability. Somebody who has had a positive experience of taking on people with disability will not need that additional assistance to convince them to take on a second, third or fourth person with some form of disability.[51]

3.56 Mr Damon Munt, Operations Manager, Employment Services at Wesley Mission agreed that wage subsidies can be a successful tool to move someone into employment. Moreover, they can facilitate effective communication between the employer, employment services provider and job seeker:

> It is quite successful. We have very high conversion rates when there is a wage subsidy attached to a placement. That wage subsidy is not just about money; it increases the engagement with the employer, us and job seeker. There is more of a partnership approach with that placement...[which means] we are able to talk through some of those issues and talk through the fact that the wage subsidy is offsetting some of the costs associated with the down time or the person having to have a day off or whatever the case may be to deal with that issue.[52]

3.57 The CCI WA cautioned that wage subsidies are not in and of themselves 'the answer':

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49 Ms Marcia Kuhne, ACCI WA, *Committee Hansard*, 18 October 2011, Perth, p. 4.

50 Mr Dale Campbell, Top End Association for Mental Health, *Committee Hansard,* 17 October 2011, Darwin, p. 19.

51 Ms Fiona Buffinton, Group Manager, Specialist Employment Services, *Committee Hansard*, 13 October 2011, Canberra, p. 3.

52 Mr Damon Munt, Operations Manager, Employment Services, *Committee Hansard*, 17 June 2011, Sydney, p. 26.

> It is one idea...It might alleviate some … concern. But I think really the training and education is a much more important part of the answer.[53]

3.58 Other witnesses drew attention to the possible pitfalls of relying on wage subsidies. Miss Kerrie Banks, Service Manager, FSG Australia enVision Programs indicated that they can be a short term solution and, if they do not lead somewhere, potentially set the client back:

> It generally only lasts around six months in our experience. Some people have been successful but the majority frequently have not been so successful in going beyond that period of time. The person not only has their self-confidence built; their social network increases and financially they gain – and they then find out that it is no longer an option for them ... It is quite difficult for people to then regroup and go, "Is this about me, my skills, my illness."[54]

3.59 Mr Kevin Rogan, Chair of the Regional Skills Formation Network, and consultant with the Regional Australians Apprenticeship Centre operating through the Career Employment Group in Whyalla, indicated that employers may not consider a $1,500 payment, paid only after a successful 13 week placement, is worth their while, especially if they subsequently have a negative experience with that person. [55]

Supported Wage System

3.60 DEEWR differentiated between wage subsidies and the Supported Wage System (SWS):

> The Supported Wage System is an industrial relations instrument where you are working as opposed to a wage subsidy, which is encouraging employers to take on somebody.[56]

3.61 The JobsAccess website outlines how the Supported Wage System works:

> The Supported Wage System is a process that allows employers to pay productivity based wages [following an approved assessors' assessment which is free to the employer] to people whose work

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53 Ms Marcia Kuhne, ACCI WA, Committee Hansard, 18 October 2011, Perth, p. 4.

54 Ms Kerrie Banks, Service Manager, FSG Australia enVision Programs, *Committee Hansard,* 8 August 2011, Gold Coast, p. 16.

55 Mr Kevin Rogan, Chair, Regional Skills Formation Network, *Committee Hansard*, 6 June 2011, Whyalla, p. 6.

56 Ms Buffinton, Group Manager, Specialist Employment Services, DEEWR, *Committee Hansard,* 14 October 2011, Canberra, p. 8.

> productivity is significantly reduced as a result of the effects of their disability. [57]

3.62 Ms Buffinton, Group Manager, Specialist Employment Services Group, DEEWR clarified:

> If somebody cannot work at the same level as a co-worker, we can send in assessors to work out what is, if you like, the percentage of productivity – it may be 70% of other workers.[58]

3.63 The DEEWR submission stated:

> From 1 July 2012, a new Supported Wage System Employer Payment will be available to employers not supported by an employment service provider who employ people whose work productivity is reduced as a result of their disability. The $2 000 incentive payment will be available to eligible employers after they have employed a person under the Supported Wage System for a minimum of 15 hours a week, for 26 weeks.[59]

3.64 Ms Melissa Williams, Manager of Gold Coast Employment Support Service pointed to concerns she had regarding the Supported Wage System, namely that a client with a mental illness has to be on the DSP in order to be eligible for it, at the same time that, in her view, fewer people are being granted DSP:

> ...if somebody needs access to the Supported Wage System, that is reliant on their eligibility for DSP. I want to know what is going to happen to those people who may require that. Some people require it early in returning to work and reach a point where they no longer require it. But they are not going to be eligible for it, so what are we going to do with those people? We have appealed and appealed for a young man for whom we have so much evidence that he cannot work at industry standard. But he does not tick the boxes for a DSP, so he cannot have supported wages, so he cannot work. I believe we will see alot more of these across disabilities, including psychiatric.[60]

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57 Australian Government, JobsAccess website, http://jobaccess.gov.au/Employers/Financial_help_and_wages/Help_with_wages/Supported_Wage_System/Pages/home.aspx

58 Ms Fiona Buffinton, Group Manager, Specialist Employment Services, *Committee Hansard*, 13 October 2011, Canberra, p. 3.

59 Joint Department Submission, *Submission 62*, p. 12.

60 Ms Melissa Williams, Manager, Gold Coast Employment Services, *Committee Hansard*, 8 August 2011, p. 12.

3.65 Ms Buffinton, Group Manager, Specialist Disability Employment Services Group, DEEWR acknowledged that the assessment for the Supported Wage System 'does not work as well as it could' for people with a mental illness, especially with regards to accommodating the episodic nature of their conditions. As such, it is under review:

> As part of the last budget it was announced that we are going to review the scheme, particularly for mental illness...The problem is, the assessor goes in with somebody with mental illness who is going through quite a positive period, and then they say this person does not need a supported wage. But, of course, it is episodic. [61]

3.66 Ms Buffinton indicated that of the review results so far:

> One thing that has come out is the need to cover absenteeism. While they are there, while they are healthy, productivity is 100 per cent, but then they get sick and it is not about reduction of productivity by 10 per cent; they do not turn up to work at all for a while. Is there a possibility for the supported wage scheme to cover the wages for those discrete periods of time – to cover getting people in to cover those sorts of situations?[62]

3.67 DEEWR advised of a delay with the review.[63]

3.68 The Supported Wage System is an important tool for removing barriers to employment for some people with a mental illness, and encouraging benefit recipients to work. The Committee supports improving its effectiveness in order to be sufficiently flexible to accommodate the episodic nature of some mental illnesses. And also, potentially assisting those with a mental illness not eligible for the DSP.

Recommendation 6

The Committee recommends that the Commonwealth Government ensure that the Supported Wage System is sufficiently flexible to accommodate employees with a mental illness by taking into account the episodic and fluctuating nature of their condition.

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61 Ms Buffinton, DEEWR, *Committee Hansard*, 13 October, p. 3.

62 Ms Buffinton, DEEWR, *Committee Hansard*, 13 October, p. 3.

63 Email from Ms Buffinton, 10 February 2012.

Enhancing communication and links between supply and demand

3.69 The Australian Chamber of Commerce and Industry (ACCI) and CCI WA provided examples of material that they have disseminated to their members about employing people with mental ill health. This includes information on managing employees with a mental illness, citing details of the Australian Human Rights Commission *Guide for Workers with a Mental Illness: A Practical Guide for Managers,* and the ACCI's plan for the employment of people with a disability, including a mental illness.[64]

3.70 Increasing engagement of the disability sector with employer associations to get key messages out to employers was one of the main points made in a 2008 ACCI submission to the discussion paper into the national mental health and disability employment strategy.[65]

3.71 ACCI restated its belief in greater engagement between the disability sector and employer associations because of the latter's capacity for outreach and leadership. Such engagement should:

> Encourage the disability sector to talk less to themselves and engage more with employer bodies and their members. Open up communication and take advantage of the association networks. Communicating with employers is a challenge, even for associations – information comes at them from all directions, particularly in small business, and it is hard to make an impact. That is why their trusted channels of information have more success.[66]
>
> For example, a very good disability provider could be very effective in developing networks within their local area but it is how you look at it from the top end as well: how you provide the leadership and mechanisms by which you can create the context for the conversation.[67]

3.72 ACCI's 2008 submission recommended that the Government consider an employer engagement project for people with disabilities that has medium to long term goals. ACCI reiterated its continued support for this approach but would now:

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64 ACCI, *Submission 71* and CCI WA, *Submission 68*, Attachments 1-3.

65 Ms Jennifer Lambert, Director, Employment, Education and Training, Australian Chamber of Commerce and Industry, *Committee Hansard*, 14 October 2011, Canberra, p. 42.

66 Ms Jennifer Lambert, Director, Employment, Education and Training, ACCI, *Submission 71*, p. 2.

67 Ms Jennifer Lambert, Director, Employment, Education and Training, Australian Chamber of Commerce and Industry, *Committee Hansard*, 14 October 2011, Canberra, p. 42.

> Broaden it to being a diversity and participation approach with sufficient resources to drive networking/workshop activities for DES/Job Services Providers to better work with employer groups and employers. The project could also interrogate the information that hopefully can be more clearly provided on where people are employed and where the opportunities for further employment can be identified.[68]

3.73 ACCI indicated that a tangible benefit to more open communication between the supply and demand side might be the ability to: 'target approaches to sectors and even jobs that are most suitable.'[69]

3.74 Ms Jennifer Lambert, Director of Employment, Education and Training at the ACCI cited an example. She said one of ACCI's leading hospitality organisations could potentially create opportunities for people with a disability, including a mental health disability, yet that is not something on the radar with the human resources managers. According to Ms Lambert, this is a missed opportunity.[70]

3.75 Ms Lambert went on to say that missed opportunities arise because employing people with a mental illness is not considered a mainstream issue, and yet that's exactly what it is:

> We are talking about a big issue; we are talking about large numbers of people with mental health issues [on benefits]...so it is mainstream in its size and dimensions but not mainstream [yet] in its employer outcomes. [71]

Creating networking opportunities as part of a broader participation approach

3.76 ACCI indicated that it is already represented on a range of different reference and advisory groups, including Job Services, DES, Indigenous, Mature Age and others.[72] However, the fragmented character of the service delivery sector inhibited engagement:

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68 Ms Jennifer Lambert, Director, Employment, Education and Training, ACCI, *Submission 71*, p. 2.

69 Ms Jennifer Lambert, Director, Employment, Education and Training, ACCI, *Submission 71*, p.1.

70 Ms Jennifer Lambert, Director, Employment, Education and Training, Australian Chamber of Commerce and Industry, *Committee Hansard*, 14 October 2011, Canberra, p. 42.

71 Ms Jennifer Lambert, Director, Employment, Education and Training, Australian Chamber of Commerce and Industry, *Committee Hansard*, 14 October 2011, Canberra, p. 42.

72 Ms Jennifer Lambert, Director, Employment, Education and Training, ACCI, *Submission 71*, p. 2.

> So many of the issues and desired outcomes for communication and engagement are the same, yet each part of Government generally works separately on these agendas.[73]

3.77 The ACCI believes that building networks between the supply and demand sides needs to occur at both the strategic and operational levels.[74]

3.78 On the strategic level, Ms Lambert said she was pleased that ACCI had recently received funding for one year, for a dedicated person to encourage greater workforce participation for mature age workers. She intimated that establishing a dedicated position to encourage greater workforce participation of those with a mental illness would be similarly useful.[75] She observed that, in both cases, a three to four year minimum commitment would be required in order to effect:

> Major cultural change and a major build up of opportunities of better connecting the supply to the demand side.[76]

'Business champions' sharing success stories and making the business case for greater inclusivity

3.79 Mental Illness Fellowship Victoria outlined one way that it had successfully brought the supply and demand sides together. The Fellowship organised an employment luncheon for about 100 employers, in order for them get to know the organisation and learn what it is they do. At the luncheon, employers shared their positive experiences in employing people with a mental health condition:

> One of the best marketing strategies was when an employer got up and talked about the success they were experiencing and what good employees we had put them with were. That was Delaware North and they were fantastic.[77]

3.80 DEEWR endorsed doing something similar:

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73 ACCI, *Submission 71*, p. 2.

74 ACCI, *Submission 71*, p. 2.

75 Ms Jennifer Lambert, Director, Employment, Education and Training, Australian Chamber of Commerce and Industry, *Committee Hansard*, 14 October 2011, Canberra, p. 42.

76 Ms Jennifer Lambert, Director, Employment, Education and Training, Australian Chamber of Commerce and Industry, *Committee Hansard*, 14 October 2011, Canberra, p. 42.

77 Ms Laura Collister, General Manager, Rehabilitation Services, Mental Illness Fellowship of Victoria, *Committee Hansard*, 13 April 2011, Melbourne, p. 7.

> Putting case studies out into national business conferences of employers engaging with people with mental illness is incredibly powerful.[78]

3.81 Major employers were supportive. The Chief Executive Officer of Dampier Salt Limited suggested:

> sponsorship of conferences or workshops where specialists can talk to employers as well as where employers can share best practice.[79]

3.82 The Department of Defence mentioned how it had successfully shared experiences of employing people with a mental illness with other APS agencies, at a Comcare[80] conference.[81]

3.83 DEEWR referred to working with companies to facilitate these types of forums, 'There are those that are open to the idea and that is the area that we are working on.'[82]

3.84 Ms Sally Sinclair, CEO of the National Employment Services Association (NESA) mentioned the national awards for excellence it issues to employers who look after the mental health and wellbeing of their employees. The awards highlight the important leadership role that employers play in the broader community, and demonstrate that employers wish to be seen to be proactive in this space:

> Last year we gave a special award to Abigroup, who provide outstanding leadership in this area, and this year we had two large employers, Brookfield Multiplex and Stockland, who sponsored the awards. They are also doing fantastic work. They cannot understand why employers are not more on the page so they saw that as a way to have direct involvement.[83]

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78 Ms Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 14 October 2011, Canberra, p. 8.

79 Ms Denise Goldsworthy, DSL, *Committee Hansard*, 18 October 2011, Perth, p. 50.

80 Comcare is the Australian government agency that partners with workers, their employers and unions to keep workers healthy and safe, and reduce the incidence and cost of workplace injury and disease. Comcare implements the Australian Government's policies in federal workplaces to drive social inclusion and productivity. See the website for more: http://www.comcare.gov.au/about_us

81 Mr Neil Tomkins, FAS, Defence People Solutions, Defence, *Committee Hansard*, 14 October 2011, Canberra, p. 26.

82 Ms Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 14 October 2011, Canberra, p. 8.

83 Ms Sally Sinclair, CEO, National Employment Services Association Ltd, *Committee Hansard,* 19 August 2011, Melbourne, p. 11.

3.85 The Committee is of the view that as important as it is for organisations like NESA, to identify and validate those employers who are proactive in looking after the mental health and wellbeing of their workforce, 'business champions' need to also self-identify and actively make the business case to others in their industry as well as the broader business community, for hiring people with a mental illness, retaining valued employees with a mental illness and fostering the mental health and well-being of all employees in a workplace. Business champions can show how workforce shortages in their industry might be filled or stopped by adopting a more inclusive approach.

3.86 There is strong evidence supporting the advantages of direct contact between stakeholders through workshops or other types of forums such as conferences.

3.87 To this end the Commonwealth Government should work with program providers and employers to disseminate information on various programs and their outcomes in workplaces.

3.88 Discussion forums for sharing 'good stories' and best practice might include the main service providers (Beyond Blue, Sane Australia etc), organisations already quite far down the path of providing integrated and tailored solutions (such as Defence, Abigroup and Rio Tinto – see later in this chapter for details) and other organisations that are interested in following suit and pursuing similar paths but specific to their own organisational needs and culture.

3.89 The Committee recommends that discussions amongst stakeholders include the development of national standards for best employer awards for recruiting and retaining employees with a mental illness, and promoting the mental health and wellbeing of all employees.

Recommendation 7

The Committee recommends that the Commonwealth Government work with employer associations and employers to promote the business case for employing people with a mental illness. This should include:

- **showcasing employers' broader workplace strategies for employing and retaining employees with a mental health condition and proactively promoting the mental health and well-being of all their employees as good human resource practice;**
- **discussion of the range of Commonwealth Government assistance available to employers;**
- **having employers share stories of successful placements of employees with mental ill health in their workplaces with others in their industry and the broader business community, including having 'business champions' speak about the business case for greater inclusivity; and**
- **jointly developing national standards for best employer awards that endorse recruiting and retaining employees with a mental illness, and promoting the mental health and wellbeing of all employees.**

Small and medium sized businesses sometimes better

3.90 NESA suggested that small and medium sized businesses were, perhaps surprisingly, typically better than the larger companies in their dealings with employees with a mental health condition:

> You would think that [small medium sized employers] would have all the attendant challenges, but they are the group that will give people a go and are very integrated in their local community.
>
> Our finalists this year [for the good employer awards], for example, were all small to medium sized employers. The employer that won was a local aged-care organisation of 50 staff.

> Historically, large companies are not in the mix when it comes to this area or more broadly employing people with disadvantage.[84]

3.91 Orygen Youth Health concurred that this was their experience:

> Many times what we have found is that employers are a bit more sympathetic to mental illness than people might imagine. A lot of the people we get are employed, like most people, in small to medium sized businesses. It is not huge corporations that are employing people. So people quite often have their own personal experiences with someone whom they know. They go, 'Oh, my cousin'; it is very common, so they are willing to take a bit of latitude.[85]

3.92 ACCI advised that the majority of the its 350,000 members were small to medium sized businesses and whilst it might be structurally easier for larger companies to have a dedicated diversity manager to cope with the issues and have a positive agenda, the opportunities for disability employment service providers to link up with small to medium sized businesses presented because:

> a small to medium sized business will be looking at their local community and saying what will be the benefit of employment engagement in their local community ... The potential [opportunity for employment] is there because of the nature of the personal relationship that small business will have with its local community.[86]

3.93 However, ACCI cautioned that some small businesses might have more concerns about the risk of hiring someone with a mental illness:

> It is easier for Woolworths or that size of business to put on a number within its multiple tens of thousands of workforce as opposed to a small business of 10 people. If [small businesses] take a risk with one, that is a bigger risk for them.[87]

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84 Ms Sally Sinclair, CEO, National Employment Services Association Ltd, *Committee Hansard,* 19 August 2011, Melbourne, p. 11.

85 Professor Killackey, Psychosocial Research, Orygen Youth Health, *Committee Hansard,* 24 March 2011, p. 9.

86 Ms Jennifer Lambert, Director, Employment, Education and Training, Australian Chamber of Commerce and Industry, *Committee Hansard*, 14 October 2011, Canberra, p. 46.

87 Ms Jennifer Lambert, Director, Employment, Education and Training, Australian Chamber of Commerce and Industry, *Committee Hansard*, 14 October 2011, Canberra, p. 46.

Assistance for the employer

JobAccess

3.94 The Committee heard that small businesses were willing to take on people with mental ill health but wanted to know that there was assistance available if they needed it.

3.95 For instance, Mr Kevin Rogan of the Regional Skills Formation Network in Whyalla referred to employers' concerns about not having the necessary resources required for the ongoing support and supervision of a worker with a mental illness.[88]

3.96 Ms Marcia Kuhne, Manager of Industrial Relations Policy of the CCI WA, made the key point that employers usually only seek assistance if they encounter a problem:

> employers tend to look for a service when they need it. That is one of the biggest issues. If there were solutions that were available and readily understood that would be part of making it mainstream, and employers would know who to go to.[89]

3.97 DEEWR referred to a free information and advice service, funded by the Commonwealth Government, to assist employees and employers.[90] JobAccess offers advice on:

- how to create a supportive and healthy work environment;
- how to search for a job and keep that job
- step-by-step guides on recruitment, adjusting a workplace and understanding rights and responsibilities at work;
- work related modifications and services for people with disability; and
- disability Employment Services and Programs.[91]

3.98 DEEWR told the Committee that JobAccess's 'main focus is employers.'[92] The JobAccess website features some case studies and success stories

88 Mr Kevin Rogan, Chair, Regional Skills Formation Network, *Committee Hansard*, 6 June 2011, Whyalla, p. 9.

89 Ms Marcia Kuhne, Manager, Industrial Relations Policy, CCI WA, Committee Hansard, Perth, 18 October 2011, p. 4.

90 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 14 October 2011, Canberra, p. 7.

91 DEEWR website, http://www.deewr.gov.au/Employment/Programs/ExpPlus/JobSeekers/Pages/Findajob.aspx viewed 23 February 2012.

92 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 13 October 2011, Canberra, p. 3.

about the benefits to business of employing people with mental ill health.[93] Although, these case studies are interspersed with the case studies about people with a physical or intellectual disability so they are not always easy to find.

3.99 JobAccess is a free service for all Australians. The website indicates that people can access the service by contacting a JobAccess advisor on **1800 464 800**.[94] The service is ongoing, provides information on services that may be available and works as a referral service as well.[95]

3.100 It is not insignificant that the Committee did not discover this number until some way through the inquiry and there was little evidence or knowledge of it among employers.[96]

3.101 Even experts were unaware of such support on offer. Dr Geoffrey Waghorn of Queensland Centre for Mental Health Research observed:

> [DEEWR} are not providing any structured form of post-employment support that I am aware of.[97]

3.102 Ms Nicole Tuckwell, Divisional Manager, Workfocus Group, an employment service provider said that:

> There is limited awareness of the free advice and services provided by JobAcess; therefore, services available to assist those with mental illness in the workplace are under-utilised.[98]

3.103 Ms Kuhne indicated that the CCI WA had recently become aware of JobAccess and would be looking to incorporate it into its training programs.[99]

3.104 DEEWR later noted that the JobAccess service has been expanded in the current Budget:

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93 JobsAccess website, http://jobaccess.gov.au/Home/Home.aspx

94 DEEWR website, http://www.deewr.gov.au/Employment/Programs/ExpPlus/JobSeekers/Pages/Findajob.aspx viewed 23 February 2012.

95 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 13 October 2011, Canberra, p. 3.

96 *Committee Hansard*, Perth, 18 October 2011, p. 3.

97 Dr Geoffrey Waghorn RM, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, *Committee Hansard*, 9 August 2011, p. 17.

98 Ms Nicole Tuckwell, Divisional Manager, Workfocus Group, *Committee Hansard*, 18 October 2011, p. 15.

99 Ms Marcia Kuhne, Manager, Industrial Relations Policy, CCI WA, Committee Hansard, Perth, 18 October 2011, p. 4.

> To include professionals in the mental health area who will provide information and support relating to the employment of people with a mental illness. This measure, which is part of the 2011-2012 Budget, also includes funding to encourage employment service providers to access the expertise of the JobAccess staff.[100]

3.105 The Committee is of the firm view that information about this service and its potential benefits for employees, employers and employment services must be more widely disseminated through appropriate channels (see Recommendation 9 further on).

Workplace modifications and adjustments

3.106 The JobsAccess website contains information on the forms of assistance available to employers, employees with a mental health condition and employment service providers to help them accommodate a worker with disability in a job:

> Assistance is available for a broad range of modifications including, but not limited to, physical and environmental workplace adjustments, computer software upgrades, vehicle modifications, communication technology devices and specific items of equipment an employee may require to do their job.[101]

Employment Assistance Fund

3.107 The Employment Assistance Fund service, accessed through a JobsAccess advisor, replaces its predecessor known as the Workplace Modifications Scheme. In respect of people with a mental illness, the Fund:

> provides assistance to employers of people with disability and mental health condition by providing financial assistance to purchase a range of work related modifications and services. Assistance is available for people who are about to start a job or who are currently working, as well as those who require assistance to find and prepare for work.[102]

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100 DEEWR, Submission 75.1, Attachment A.

101 The Australian Government, Jobs Access Website, http://jobaccess.gov.au/Employers/Financial_help_and_wages/Workplace_modifications_and_adjustments/Pages/home.aspx

102 The Australian Government, Jobs Access Website, http://jobaccess.gov.au/Employers/Financial_help_and_wages/Workplace_modifications_and_adjustments/Pages/home.aspx

3.108 The Fund may reimburse the cost of work-related modifications and services, including:

- Specialists services for employees with mental health conditions; and
- Mental health first-aid training.[103]

3.109 The Employment Assistance Fund also provides a free workplace assessment to help identify the required modifications.

3.110 Like the JobAccess service itself, the Committee heard few details of the Fund and how it operates exactly.

3.111 The joint department submission supplied the following information about the service:

> Employment service providers may also access specialist mental health counselling and stress and behaviour management services from the Employment Assistance Fund to assist people experiencing problems as a result of their condition.[104]

3.112 There appears limited knowledge of this service too though. WorkFocus said of it:

> The Employment Assistance Fund could include more support for mental health issues in the workplace. For some job seekers with mental ill health, the current levels leave service gaps and are not significant enough to provide full support. Additionally, in line with the preceding point [about the limited awareness of free advice and services provided by JobAccess], a lack of awareness means that the support offered by the Fund is underutilised at present.[105]

Jobs in Jeopardy (JiJ)

3.113 Jobs in Jeopardy is an intervention provided by disability employment services (DES) providers to assist employments at risk of losing their employment as a result of their disability or health condition, including mental illness:

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103 The Australian Government, Jobs Access Website, http://jobaccess.gov.au/Employers/Financial_help_and_wages/Workplace_modifications_and_adjustments/Pages/home.aspx

104 Joint department submission, *Submission 62*, p.27

105 WorkFocus Group, *Submission 32*, p. 2.

> The employee can present to any DES provider of their choice, in their area, and the DES provider can commence helping them immediately. The DES provider works flexibly with the participant, and if required, their employer, delivering an individual program of assistance that helps the participant retain their employment.[106]

3.114 There was scant mention (a one sentence description) of the program in the Government's joint submission.[107]The Department of Human Services website has limited information about the program on it. There does not appear to be a phone number specifically for Jobs in Jeopardy, but rather a directive to your nearest DHS Service Centre.[108]

3.115 Mr Damon Munt, Operations Manager, Employment Services, Wesley Mission and Mr Andrew Mitchell, Director of Mental Health, Employment and Counselling, alluded to a lack of awareness surrounding the Jobs in Jeopardy program.[109]

3.116 Wesley Mission suggested that there needs to be an awareness campaign, through employer industry groups, about the benefits of the program, because 'it is virtually unknown in the general community.'[110]

3.117 DEEWR acknowledged that not all employers are aware of the existence of a program like Jobs in Jeopardy.[111]

3.118 Beyond limited knowledge of the program, take-up of support offered by Jobs in Jeopardy was obstructed by reluctance on the parts of employers and employees to acknowledge a need for it. Mr Munt explained:

> When we have promoted [the program] locally to employers one of the first responses we get is, 'We do not have anyone with disabilities who works here'. They are not interested because they claim to not have anyone with a disability or mental illness.
>
> We try to explore that further by asking how many employees they have. If they say they have 50 we tell them they may not be aware of that. You may have absenteeism or people who are not

106 DEEWR, FaHCSIA and DoHA, *Submission 62,* p. 26.

107 DEEWR, FaHCSIA and DoHA, *Submission 62,* p. 26.

108 DHS website, http://www.humanservices.gov.au/customer/services/centrelink/job-in-jeopardy

109 Mr Damon Munt, Operations Manager, Employment Services, Wesley Mission, *Committee Hansard,* 17 June 2011, Sydney, pp. 28-29.

110 Wesley Mission, *Submission 47,* p. 9.

111 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 14 October 2011, Canberra, p. 10.

> functioning in the job...It may just be job dissatisfaction and the like, but there may be underlying issues that they are not aware of. But if they then go and talk to the employees, the employees do not want to turn around and say, 'By the way, I am struggling in the job because I have a mental health issue.[112]

3.119 DEEWR referred to a 2008 review of JiJ that found failings:

> Although the program is flexible in meeting the needs of people with disability who require support in the workplace in order to maintain their employment, awareness and understanding of the JiJ program is low amongst people with disability and their employers. [113]

Earlier access

3.120 Ms Janet Bromley, Manager, Services, Lantern, explained that there is a qualifying period before a program like Jobs in Jeopardy can be accessed. She postulated that this might be a period of 12 months. She stressed that does not help people in a job who experience difficulties earlier than the prescribed qualifying period.[114] According to Lantern:

> The first weeks of any new job are often when there is the greatest risk of losing the job due to increased levels of anxiety and stress associated with a new role.[115]

3.121 The Department of Human Services (DHS) referred to the Jobs in Jeopardy program as a 'safety net option' and mentioned other interventions that might occur earlier, including approaching CRS Australia (formerly known as the Commonwealth Rehabilitation Service) or DES providers for assistance.[116]

3.122 The Jobs In Jeopardy website states that to be eligible for assistance:

> You must have been employed for at least 8 hours a week on average over the last 13 weeks, and not be receiving assistance from another employment services provider. Customers who

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112 Mr Damon Munt, Operations Manager, Employment Services, Wesley Mission, *Committee Hansard,* 17 June 2011, Sydney, pp. 28-29.

113 DEEWR, *Submission 75.1*, p. 6.

114 Ms Janet Bromley, Manager, Services, Lantern, *Committee Hansard*, 19 August 2011, Melbourne, p. 16.

115 Lantern, *Submission 22,* p. 4.

116 Ms Malisa Golightly, Deputy Secretary, Health and Older Australians, Department of Human Services, *Committee Hansard*, 14 October 2011, Canberra, p. 13.

> meet this requirement can approach a DES directly for assistance or Centrelink for information on links to local providers.[117]

3.123 DEEWR clarified that the Jobs in Jeopardy program is actually accessible to people before 13 weeks 'if there is an expectation that the employment will last 13 weeks'.[118]

3.124 Ms Denise Fredericks, Divisional Manager, Victoria/Tasmania, CRS Australia told the Committee that, from her perspective, it was a satisfying program to be involved in:

> The Jobs in Jeopardy program is a program that we love to engage in...There are some eligibility criteria, but it gives us the opportunity to go into that workplace and work with both the employer and employee to sustain that employment. There may be things like education and training within the workplace that might help other employees understand the situation. We might look at job redesign...and whether some simple changes could be made that could accommodate that. Some of the things we might do there would be to look at: is it the shifts that that particular job seeker is working that are impacting on their mental health problems? We would then liaise with the employer to keep the employee working but have the job arranged slightly differently for that person.[119]

3.125 Mrs Donna Faulkner, Chairperson of Board of Directors, Disability Employment Australia and Executive Director of Work Solutions, Gippsland also praised the program and its potential:

> I wanted to compliment DEEWR on the great Jobs in Jeopardy initiative...I have had the opportunity to work with some rather large employers...it gives us an opportunity to minimise the stigma attached to workers and to assist them to rescue their job, rescue their opportunities – rescue their life, really.[120]

3.126 It strikes the Committee that there is a limited knowledge about the JobAccess, Employment Assistance Fund and Jobs in Jeopardy Program alike.

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117 Centrelink website, http://www.centrelink.gov.au/internet/internet.nsf/services/jobs_jeopardy.htm

118 Answers to questions taken on notice at hearing n 14 October 2011, DEEWR, *Submission 75*, p. 5.

119 Ms Denise Fredericks, Divisional Manager, Victoria/Tasmania, *Committee Hansard*, 4 November 2011, p. 21.

120 Mrs Donna Faulkner, Chairperson of Board of Directors, Disability Employment Australia and Executive Director, Work Solutions Gippsland, *Committee Hansard*, 13 October 2011, p. 9.

3.127 If there is to be a greater uptake of all these initiatives, there needs to be a clearer and more actively promoted communication strategy about what services are on offer, how they can assist employees and employers alike, and the process to follow for accessing the available support services.

3.128 Specifically in relation to Jobs in Jeopardy, the website also needs to make it quite clear that there is, in fact, a minimal qualifying period. Having 'an expectation that employment will last 13 weeks' appears an arbitrary qualification and difficult to prove. The whole process needs to be made more transparent and be available early on in the piece. The criteria for access should certainly be relaxed when necessary, particularly given the under utilisation of the program. It may be immaterial that someone is receiving assistance from an employment service provider, if this just means that 'they are on the books' and not otherwise receiving active support to maintain their employment.

3.129 The Committee notes that the JobAccess website contains some case-studies and success stories of people with mental illnesses helped through JobsAccess.[121]

3.130 The Employment Assistance Fund and Jobs in Jeopardy websites need to make it clearer how employers can use them to help people with a mental illness in their workplaces.

121 JobAccess website, http://jobaccess.gov.au/Employers/Case_studies_and_success_stories/Pages/home.aspx

Recommendation 8

The Committee recommends that the Commonwealth Government support and, where necessary, amend the JobAccess, Employment Assistance Fund and Jobs in Jeopardy initiatives to ensure that:

- **the scope of eligibility requirements does not prohibit employees and employers who require support; and**
- **ways of accessing and information about the JobAccess, Employment Assistance Fund and Jobs in Jeopardy programs and their benefits, including for employment of people with a mental illness, be clarified and readily available to employees and employers.**

All these programs need to be promoted more widely and their websites kept updated.

Written resources for employers

3.131 In response to an assertion by Safe Work Australia that there was an absence of guidance material for employers in relation to supporting workers with mental ill health, [122] the Australian Human Rights Commission produced a document titled *2010 Workers with mental illness: a practical guide for managers*.[123] That guide is supported by Safe Work Australia and endorsed by the Fair Work Ombudsman, Beyondblue, the Mental Health Council of Australia and Sane Australia.[124]

3.132 The AHRC guide offers comprehensive advice to managers and employers about how to meet their obligations towards all workers in their business, including workers with mental illness.

3.133 The AHRC Guide states that beyond meeting legal obligations, other reasons for developing mental health strategies in the workforce include:

- Because a safe and health workplace is good for business
  - ⇒ Reducing costs associated with worker absence from work and high worker turnover;

122 AHRC, *Submission 44*, p. 4.

123 The document can be downloaded from the AHRC website: http://www.hreoc.gov.au/disability_rights/publications/workers_mental_illness_guide/workers_mental_illness_guide.pdf

124 AHRC, *Submission 44,* p. 4.

- ⇒ Achieving greater staff loyalty and a higher return on training investment;
- ⇒ Minimising stress levels and improving morale;
- ⇒ Avoiding litigation and fines for breaches of health and safety laws; and
- ⇒ Avoiding industrial disputes.

- Because it improves productivity
- Because society and workplaces are diverse
- Because mental illness can affect anyone.[125]

3.134 The Guide provides advice on how to create a safe and healthy workforce through identifying possible workplace practices, actions or incidents which may cause, or contribute to, the mental illness of workers and taking actions to eliminate or minimise those risks.[126] Such measures include:

- having effective policies and procedures;
- offering flexible working arrangements; developing mentoring and peer support systems;
- providing access to counselling services and/or specialist support groups;
- developing a greater understanding through education and training; [and]
- ensuring safe and healthy work conditions.[127]

3.135 The AHRC guide contains contact details for National Mental Health Services such as beyond blue, headspace, SANE Australia and the Australian Psychological Society.[128]

3.136 ACCI endorsed the usefulness of the AHRC Guide and similar resources for employers.[129] To this end, the Guide was promoted in one of its Business Bytes circulars:

125 AHRC website, 2010 Guide for Workers with Mental Illness: A Practical Guide for Managers, http://www.hreoc.gov.au/disability_rights/publications/workers_mental_illness_guide/chapter1.html#s1_1

126 AHRC website, 2010 Guide for Workers with Mental Illness: A Practical Guide for Managers, http://www.hreoc.gov.au/disability_rights/publications/workers_mental_illness_guide/chapter1.html#s1_1

127 AHRC website, 2010 Guide for Workers with Mental Illness: A Practical Guide for Managers, http://www.hreoc.gov.au/disability_rights/publications/workers_mental_illness_guide/chapter4.html

128 AHRC website, 2010 Guide for Workers with Mental Illness: A Practical Guide for Managers, http://www.hreoc.gov.au/disability_rights/publications/workers_mental_illness_guide/chapter5.html#s5_2

129 Ms Lambert, Director, Employment Education and Training, ACCI, *Committee Hansard*, 14 October 2011, Canberra, p. 42.

> There is a real business case for managing employees who suffer from mental illness. The AHRC report estimated that stress related workers compensation claims cost in excess of $10 million per year. In addition to this cost, businesses lose billions of dollars each year by not implementing early intervention strategies.
>
> The guide suggests a number of practical strategies for employers managing employees with a mental illness or suspected mental illness. The strategies are based on the principles of effective and open communication, making reasonable adjustments and focusing on pragmatic solutions. [130]

3.137 Disseminating information about written resources – together with information about programs like JobAccess and Jobs In Jeopardy – through employer associations can may play a part in a more effective communication strategy.

3.138 Nonetheless, these important messages do not always reach their intended audience. ACCI expressed concern that:

> really [the guide and similar resources] would not hit the mainstream employer distribution...even if they came into the inbox of the average employer, it does not engage because it is a crossover between a research and selling document about the importance of the issue and the practical things, so it tried to be many things to many people.[131]

3.139 NSW Consumers Advisory Group noted a similar issue with guides that they have produced saying that the guides appear not to have been distributed widely or been well understood by employers.[132]

3.140 Ms Nicole Tuckwell, Divisional Manager, WorkFocus Group agreed, saying that, perhaps in a crowded space, the messages just do not resonate:

> We find we are getting the messages out to employers via their peak industries, through the likes of the ACCI and Australian Human Resources Institute, and yet is just not being heard.[133]

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130 CCI WA, *Submission 68,* Attachment A.

131 Ms Lambert, Director, Employment Education and Training, ACCI, *Committee Hansard*, 14 October 2011, Canberra, p. 42.

132 NSW Consumer Advisory Group, *Submission 42*, p. 5.

133 Ms Nicole Tuckwell, Divisional Manager, WorkFocus Group, C*ommittee Hansard*, 18 Perth 2011, Perth, p. 16.

Importance of early intervention and prevention

3.141 The importance of early intervention and prevention in education and employment is an underlying and recurrent theme in this report.

3.142 In relation to productivity of employees with a mental health condition, Mr Bolton, Senior Advisor, Employment, Education and Training, ACCI said:

> One of the greatest issues I feel needs to be addressed is the actual breaking of the cycle of mental health issues that prevent engagement with the workforce [and that, in turn, may contribute to a deterioration of mental health]...Having early interventions to break that cycle, preferably while people are in the workforce or in education and training moving towards employment, would be an ideal scenario.[134]

Legislation

3.143 A legislative framework is an important starting point or foundation underpinning the employer's responsibilities and the employee's rights. However, it is largely a reactive instrument that is invoked after discrimination is experienced by an employee.

3.144 The CCI WA referred to the plethora of legislative instruments that already exist, as part of general human resources management, to protect employees with mental ill health from suffering discrimination or adverse action in the workplace. These include the *Fair Work Act 2009* (Cth); the *Disability Discrimination Act 1992* (Cth) and relevant state occupational health and safety legislation.[135]

3.145 AHRC further noted that for people with mental ill health living in Australia, the right to work is recognised in the Convention on the Rights of Persons with Disabilities, ratified by Australia on 17 July 2008.[136]

3.146 CCI WA set out in detail some of the current provisions that employers are bound by under the Fair Work Act and affirmed that:

> The current employment law framework provides adequate support and protection for employees suffering from mental illness.[137]

134 Mr Stephen Bolton, Employment, Education and Training, Australian Chamber of Commerce and Industry, *Committee Hansard*, 14 October 2011, Canberra, p. 43.

135 CCI WA, *Submission 68*, p. 3.

136 Australian Human Rights Commission, *Submission 44*, p. 1.

3.147 The ARHC recommended that the National Employment Standards set out at Part 2-2 of the Fair Work Act be amended to so that the right to request flexible working arrangements include people with disability. Currently, the right to flexible working arrangements is restricted to parents and people with caring responsibilities. The ARHC stated:

> Expanding this right to people with disability will enable people with disability to have the same right to request flexible working arrangements. This has been the law in the UK now for several years.[138]

3.148 The CCI WA opposed the AHRC's suggestion, stating that employees suffering from mental illness already have the ability to request flexible working arrangements:

> Notwithstanding the ability to make an individual flexibility arrangement (IFA) with the employer, employees suffering from mental ill health can enter into other flexibility arrangements such as working from home, reduced working hours or removing/substituting particularly stressful aspects of a job. Flexibility arrangements can also be utilised to allow employees suffering from mental illness to attend appointments, counselling and make any necessary arrangements.[139]

3.149 The right to request flexible work arrangements has been and is the subject of numerous recent and on-going reviews and the subject of a private members bill, the Fair Work Amendment Bill (Better Work/Life Balance), which has been reviewed by this Committee. Any amendment to the Fair Work Act along the lines proposed by AHRC should be considered in light of these other comprehensive reviews.[140]

Employee Assistance Programs (EAPs)

3.150 The Employee Assistance Professional Association of Australasia Inc. website defines an EAP as:

137 CCI WA, *Submission 68*, p. 4.

138 Australian Human Rights Commission, *Submission 44*, p. 4.

139 ACCI, *Submission 68*, p. 7.

140 See paragraphs 1.6 to 1.9 of the Committee's Advisory Report on the Fair Work Amendment (Better Work/Life Balance) Bill 2012.

> A work-based intervention program designed to enhance the emotional, mental and general psychological wellbeing of all employees and includes services for immediate family members.[141]

3.151 EAPs are touted as preventative and proactive:

> The aim is to provide preventative and proactive interventions for the early detection, identification and/or resolution of both work and personal problems that may include, but are not limited to ...depression, anxiety disorders [and] psychiatric disorders.[142]

3.152 However, the usefulness of EAPs appears a mixed picture. Dr Bowers, CEO of the Australasian Centre for Remote and Rural Mental Health, described EAPs as a reactive strategy. [143] Like legislative instruments they are often utilised after the event.

3.153 Mr Neville Tomkins, First Assistant Secretary, Defence People Solutions, Department of Defence spoke highly of the EAP provisions at Defence as one of the tools utilised for keeping their employees mentally fit 'the EAP service is something that is vital to the health of our own staff.'[144]

3.154 However, he also acknowledged that the participation rate is low – something he says that is no different to any other organisation. Nonetheless it is a service available to all staff, and their families, to discuss work and non-work related issues.[145]

3.155 Ms Sarah Marshall, National Environmental and Sustainability Manager, Abigroup Ltd suggested that EAPs are not suited to all industries. For example, in the construction industry:

> ...EAP will not work. Some of the guys on site are not going to call a phone number to a stranger whose face they have never seen. EAP is one tool that you can use that may work for some of the office workers.[146]

3.156 SANE Australia agreed:

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141 Employee Assistance Professional Association of Australasia Inc. Website, http://www.eapaa.org.au, viewed 21 January 2012.

142 Employee Assistance Professional Association of Australasia Inc. Website, http://www.eapaa.org.au, viewed 21 January 2012.

143 Dr Jennifer Bowers, *Committee Hansard*, 24 November 2011, Canberra, p. 3.

144 Mr Neville Tomkin, FAS, Defence People Solutions, Department of Defence, *Committee Hansard,* 14 October 2011, Canberra, p. 22.

145 Mr Neville Tomkin, FAS, Defence People Solutions, Department of Defence, *Committee Hansard,* 14 October 2011, Canberra, p. 22.

146 Ms Sarah Marshall, National Environmental and Sustainability Manager, Abigroup Ltd, *Committee Hansard*, 9 August 2011, Brisbane, p. 40.

> While they can be really effective up to a point, they are certainly not the answer for everybody.
>
> Many workplaces have employment assistance programs and they often will feel that they do not need to do much else. [147]

3.157 Mr Bo Li, Senior Policy Advisor, Professional Practice, Australian Psychological Society, also cautioned against interpeting EAPs as the whole answer:

> I think it is unfortunate that employers see EAP as a way of outsourcing their responsibilities...and not have the adequate mental health literacy to understand that it does not require specialist mental health intervention to maintain somebody's psychologically healthy profile.[148]

3.158 Dr Caryl Barnes, Consultant Psychiatrist, Black Dog Institute concurred:

> The problem is if people think they have fixed it by sending the employee to 10 sessions of EAP and they do not have to handle it anymore, and say 'You should be fixed now'...that can be unhelpful.[149]

3.159 Dr Rebecca Matthews, Manager, Practice Standards and Resources, Australian Psychological Society said:

> there is no connection back to the employer. It is sort of that stigma story again. I think really what the ideal would be is that there is some sort of contracting arrangement with the individual that certain things get fed back to the employer, which will then improve their situation within the workplace and also offer them support .... that is not always what employees want. So, it is tricky.[150]

3.160 Dr Barnes acknowledged that EAP services have a role to play, but indicated that beyond sending somebody out to an EAP, managers may need additional support in the workplace.[151]

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147 Ms Barbara Hocking, CEO, SANE Australia, *Committee Hansard*, 13 April 2011, Melbourne, p. 25.

148 Mr Bo Li, Senior Advisor, Professional Practice, Australian Psychological Society, *Committee Hansard*, 19 August 2011, Melbourne, p. 33.

149 Dr Caryl Barnes, Consultant Psychiatrist, Black Dog Institute, *Committee Hansa*rd, 17 June 2011, Sydney, p. 6.

150 Ms Rebecca Matthews, Manager, Practice Standards and Resources, Australian Psychological Society, *Committee Hansard,* 19 August 2011, Melbourne, p. 33.

151 Dr Caryl Barnes, Consultant Psychiatrist, Black Dog Institute, *Committee Hansa*rd, 17 June 2011, Sydney, p. 6.

3.161 Mr Michael Sluis, Community Programs Manager, Black Dog Institute, observed that the culture of the workplace is perhaps more important than whether an EAP is in place, or a particular training session takes place:

> As you look around an organisation, are there posters on the wall that demonstrate the values espoused in those sessions? What are people around the water cooler saying about employees who have perhaps experienced a mental illness at work and how were they treated? So there is a level of very subtle cultural and behavioural things that employees are keenly aware of.[152]

3.162 Ms Jacqui Wallace, Strategic Programs Manager, Black Dog Institute highlighted how key the relationship between the employee and their direct manager is developed:

> There needs to be boundaries and expectations on both sides, but it is important to ensure that communication is comfortable and open and that the manager is well skilled to be able to deal with that.[153]

3.163 Beyondblue supported this view:

> research suggests that the support of the manager or supervisor is the most strongly associated factor in successful job retention for people who experience mental illness.[154]

3.164 Professor Vijaya Manicavasagar, Director of Psychological Services at Black Dog Institute spoke of the need to remove fear in workplaces about employing people with a mental health condition and the importance of education programs that talk about treatment options and how these conditions are practicably managed.[155]

3.165 Mr Nicholas Arvanitis, Program Manager, Employment and Workforce, Beyond Blue, noted that EAPs are a less common feature of the small to medium business sector because of their cost, 'Small and medium businesses do not have the resources to provide an EAP'.[156]

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152 Mr Michael Sluis, Community Program Manager, Black Dog Institute, *Committee Hansard,* 17 June 2011, pp. 6-7.

153 Ms Jacqui Wallace, Strategic Programs Manager, Black Dog Institute, *Committee Hansard*, 17 June 2011, Sydney, p. 5.

154 Beyondblue, *Submission 21*, p. 8.

155 Professor Vijaya Manicavsagar, Black Dog Institute, *Committee Hansard*, 17 June 2011, Sydney, p. 4.

156 Mr Nicholas Arvanitis, Program Manager, Employment and Workforce, Beyond Blue, *Committee Hansard*, 19 August 2011, Melbourne, p. 6.

Education and training in the workplace

3.166 Dr Barnes, also from Black Dog Institute, echoed colleague Professor Manicavasagar's remarks and said that consideration of employees with a mental health condition should be no different to accommodating those with a physical ailment:

> In the physical disability range we talk about reasonable adjustments for someone to get back into work. I think we really need to get the adjustments that we need for mental health considered at the same pitch.[157]

3.167 There are various ways to foster a workplace culture in which employees, managers and employers are as comfortable discussing ways to manage a mental health condition as a physical one in the workplace.

3.168 Witnesses referred to a range of strategies, from educational workshops and e-learning programs to more integrated workplace programs that seek to comprehensively counter stigma, encourage inclusivity and promote mental resilience.

Mental health awareness training to increase mental health literacy

3.169 Beyondblue indicated how critical mental health awareness training is in workplaces across Australia:

> Job strain has shown to … be linked to people experiencing depression. Seventeen percent of depression is actually attributable to pressures within the workplace. We need to … look at what is happening within the workplaces across Australia so that people understand the policies and practices that they can put into place to minimise the impact of work on their employees.[158]

3.170 Black Dog Institute added that:

> That type of [work] stress is more likely to exacerbate other types of mental illness, such as bipolar or psychotic illness.[159]

3.171 Beyondblue and Black Dog Institute identified mental health awareness training as key to breaking down barriers. [160] Recent research by Beyondblue and Beaton Research and Consulting indicates that:

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157 Dr Caryl Barnes, Black Dog Institute, Black Dog Institute, *Committee Hansard*, 17 June 2011, Sydney, p. 4.

158 Ms Therese Fitzpatrick, National Workplace Program Manager, Beyondblue, *Committee Hansard*, 19 August 2011, Melbourne, p. 2.

159 Dr Caryl Barnes, Consultant Psychiatrist, *Committee Hansard*, 17 June 2011, Sydney, p. 2.

> People who had … undertaken mental health awareness training had lower levels of stigma and a greater ability to … understand what to do.[161]

3.172 Professor Helen Christensen, President, International Society for Research on Internet Interventions, said the aim of such training is to increase people's mental health literacy:

> Teaching people what the disorders are, what the risk factors are and trying to tackle the stigma associated with coming out and talking about them or reacting in a normal way to somebody who has a problem.[162]

Mental health first aid

3.173 Programs for mental health literacy include the Mental Health First Aid (MHFA) program developed by Professor Tony Jorm and Ms Betty Kitchener OAM of the University of Melbourne. MHFA is:

> The help provided to a person developing a mental health problem or in a mental health crisis, until appropriate professional treatment is received or until the crisis resolves.[163]

3.174 MHFA runs education courses for employees to learn how to apply mental health first aid to their co-workers. Taught by MHFA instructors who qualify to teach following a five day training course, it increases knowledge, reduces stigma and increases supportive actions for people working in human services, including police officers, prison officers, high school teachers, TAFE and university lecturers, social and welfare workers, Aboriginal health workers, occupational therapists, lawyers and anyone in a team leader or management role. The program has won awards and been rolled out in 15 other countries.[164]

3.175 MHFA offers a range of courses. The Standard Course teaches adults how to provide initial support to adults who are developing a mental illness or experiencing a mental health crisis. Participants learn the signs and

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160 Ms Therese Fitzpatrick, National Program Manager, Beyondblue, *Committee Hansard*, 19 August 2011, Melbourne, p. 2 and Dr Caryl Barnes, Consultant Psychiatrist, Black Dog Institute, *Committee Hansard*, 17 June 2011, p. 3.

161 Ms Therese Fitzpatrick, National Workplace Program Manager, Beyondblue, *Committee Hansard*, 19 August 2011, Melbourne, p. 2.

162 Professor Christensen, President, International Society for Research on Internet Interventions, *Committee Hansard*, 13 May 2011, Canberra, p. 6.

163 Mental Health First Aid website, http://www.mhfa.com.au/cms/

164 Mental Health First Aid website, http://www.mhfa.com.au/cms/

symptoms of a range of mental health problems, where and how to get help and what sort of help is the most effective.[165]

3.176 A number of witnesses endorsed this type of course. Mr Jim Buultjens, CEO, Fairhaven Service emphasised:

> there needs to be more training and awareness of mental health issues. We recommend that there be more funded places in mental health first aid and other courses relevant to mental ill health.[166]

Beyond Blue's National Workplace Program

3.177 The Beyondblue mission is to increase the capacity of the broader Australian community to understand mental illness, specifically to prevent depression and respond effectively.[167] It also aims to provide a national focus and galvanise community leadership on the topic.

3.178 The Beyondblue National Workplace Program (NWP) is an awareness raising, early intervention and prevention program specifically for workplace settings which aims to increase the knowledge and skills of staff and managers to address mental health issues in the workplace. [168]

3.179 Over 40 Beyondblue accredited facilitators, who are located in every state and territory capital city, and in a range of regional and rural centres, deliver the NWP. The facilitators have a tertiary qualification in mental health and at least two years clinical experience treating adults for depression, anxiety and related substance use plus experience in adult education. The program works closely with the Beyondblue Employment and Workforce Program which focuses on research, policy and best practice.[169]

3.180 Beyondblue, includes among the program's successes:

- presented to over 400 organisations and 40,000 participants in Australia.

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165 Mental Health First Aid website, http://www.mhfa.com.au/cms/

166 Mr Jim Buultjens, CEO, Fairhaven Services, *Committee Hansard*, 30 August 2011, Gosford, p. 1.

167 Beyondblue website, http://www.beyondblue.org.au/index.aspx?link_id=2.524 viewed 27 January 2012.

168 Beyondblue website, http://www.beyondblue.org.au/index.aspx?link_id=2.524 viewed 27 January 2012.

169 Beyondblue website, http://www.beyondblue.org.au/index.aspx?link_id=2.524 viewed 27 January 2012.

- independently evaluated in Australia with proven outcomes for organisations and employees . It has been shown consistently to significantly:
  - ⇒ increase awareness
  - ⇒ decrease stigma
  - ⇒ improve attitudes
  - ⇒ increase confidence to assist someone to seek help.
- piloted successfully in the UK through the Sainsbury Centre of Mental Health after a global search for an early intervention program for workplaces. The program is now licensed in the UK under Impact on Depression. As part of this process it was independently evaluated by the University of Nottingham in the UK.
- awarded the Australian Institute of Training and Development "Excellence in a Learning Resource" in 2008.
- adapted for specific targeted workplace audiences including Victoria Police, Legal, Accountants, Rural and Professional Sports. [170]

3.181 Key clients include ANZ Bank, Australian Federal Police, Australian Football League, Minter Ellison, Optus, Victorian TAFE Association and VicRoads.[171]

3.182 The Beyondblue National Workplace Program has been in operation since 2004, and continues to evolve:

> When it started there was a key focus on people actually not knowing what depression and anxiety were. What we have found over the last couple of years is that people are asking 'What do we do?' We understand what it is, but what can we actually do about it. It has been fantastic to actually watch as the different industries start to talk to us ...It started with a lot of government organisations and then moved to business professional services. We are also now working with a lot of mining, construction and transport type industries.[172]

3.183 Beyond Blue drew attention to the need to tailor messages to different industries:

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170 Beyondblue website, http://www.beyondblue.org.au/index.aspx?link_id=2.524 viewed 27 January 2012.

171 Beyondblue website, http://www.beyondblue.org.au/index.aspx?link_id=2.524 viewed 27 January 2012.

172 Ms Therese Fitzpatrick, National Program Manager, Beyondblue, *Committee Hansard*, 19 August 2011, Melbourne, p. 2.

> I think it is really important that you have someone who understands that industry talking to them... at the same time the key messages are the same and you think about how you present those in a different way. If you are going to speak to a construction group, go into their crib hut ... do not bring them into an office in the city. Also thinking about the different pressures in different jobs; so you compare the legal profession to someone who is working outdoors or in construction, and you would be talking about quite different things.[173]

3.184 The Beyondblue website provides further information on the industry-specific programs that they offer.[174]

Black Dog Institute

3.185 Established in 2002, the Black Dog Institute is a not-for-profit, educational, research, clinical and community-oriented facility offering specialist expertise in depression and bipolar disorder. Attached to the Prince of Wales Hospital, it is affiliated with the University of New South Wales[175]

3.186 Black Dog has been running its workplace training programs since 2010. Like Beyondblue, Blackdog works with a range of larger organisations, including Qantas, NSW Police and the Commonwealth Bank.[176] Industry specific programs include specialised programs for the legal profession, protective services and sporting bodies.[177]

3.187 Black Dog runs its Workplace Mental Health and Wellbeing Programs, based on the findings of over 20 years of research. Drawing on current evidence-based research the program aims to:

> Develop healthy, happy workplace environments by increasing awareness to mood disorders, building skills in resilience, stress

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173 Ms Therese Fitzpatrick, National Program Manager, Beyondblue, *Committee Hansard*, 19 August 2011, Melbourne, p. 3.

174 Beyondblue website, http://www.beyondblue.org.au/index.aspx?link_id=4.1032 viewed 27 January 2012.

175 BlackDog Institute website, http://www.blackdoginstitute.org.au/public/communityeducation/workplace/index.cfm viewed 27 January 2012.

176 Dr Caryl Barnes, Consultant Psychiatrist, Black Dog Institute, *Committee Hansard*, 17 June 2011, Sydney, p.3.

177 Black Dog Institute website, http://www.blackdoginstitute.org.au/public/communityeducation/workplace/programs.cfm#Industryspecific viewed 27 January 2012.

> management and developing skills in managing individuals with mood disorders.[178]

3.188 The Workplace Mental Health and Wellbeing Program pitches courses to all staff, as well as conducting others specific to managers, team leaders and HR managers, and CEOs, directors and senior executives.[179]

3.189 Black Dog employs psychologists and general practitioners to run its programs. The organisational also calls upon a range of volunteers and ambassadors who play a contributory role in 'breaking down barriers and destigmatising.'[180]

3.190 Black Dog Institute expressed a concern that it is only the larger businesses and organisations that can afford to purchase their programs. They would like to see incentives to encourage more equitable access by organisations with fewer resources:

> Sadly, we have been approached by other organisations, some in remote areas and some smaller organisations, and have started to plan a program and have then had to pull it either because they have not had the support higher up in their organisation to get us through or because of a lack of funding.[181]

3.191 Like Beyondblue, Black Dog Institute seeks to tailor its programs to the employer. Dr Barnes described how programs are individualised:

> If someone approaches us then we do quite a bit of work with them to try and work out why they are approaching us ... We will have a couple of meetings with them to make sure that the content is going to be addressing those issues there.[182]

3.192 While some companies approach organisations like Beyondblue and Black Dog Institute proactively to run their programs for health and economic reasons, it could often be the case that they are called in post-crisis, after

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178 Black Dog Institute website, http://www.blackdoginstitute.org.au/public/communityeducation/workplace/index.cfm viewed 27 January 2012.

179 BlackDog Institute website, http://www.blackdoginstitute.org.au/public/communityeducation/workplace/index.cfm viewed 27 January 2012.

180 Dr Caryl Barnes, Consultant Psychiatrist, Black Dog Institute, *Committee Hansard*, 17 June 2011, Sydney, p.3.

181 Dr Caryl Barnes, Consultant Psychiatrist, Black Dog Institute, *Committee Hansard*, 17 June 2011, Sydney, p. 3.

182 Dr Caryl Barnes, Consultant Psychiatrist, Black Dog Institute, *Committee Hansard*, 17 June 2011, Sydney, p. 3.

an employee has suicided or been unwell and there have been issues around that.[183]

SANE Australia's Mindful Employer Program: moving towards a preventative and integrated workplace strategy

3.193 SANE Australia, the national mental health charity stressed the importance of systemic and ongoing workplace education. This is not just important amongst managers but also:

> so that co-workers are knowledgeable, understanding and supportive, because the best human resources practices can be sabotaged by co-workers who do not understand why certain decisions are being made.[184]

3.194 To these ends, SANE Australia is developing its own workplace program, called the Mindful Employer Program. The Program comprises components designed to provide employers and employees with the skills and knowledge to effectively respond to mental illness in the workplace.[185]

3.195 Unlike Beyond Blue and Black Dog Institute's approach to education and training via short workshops, the Mindful Employer Program packages a range of services that look at overall policies in the workplace, education and support for people with mental illness.[186]

3.196 SANE Australia also issues workplaces a certificate to advertise they have been found to be mindful employers. These certificates provide:

> public recognition for all people in the workplace as well as the outside world that [employers] have considered this issue, that it is supportive and understanding and that wants to make sure that they keep good people at work so that they have the best possible workers...[187]

3.197 The Mindful Employer Program is relatively new. Ms Hocking said that one workplace had signed up for the program, with two or three about to

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183 Dr Caryl Barnes, Consultant Psychiatrist, Black Dog Institute, *Committee Hansard*, 17 June 2011, Sydney, p. 3.

184 Ms Barbara Hocking, CEO, SANE Australia, *Committee Hansard*, 13 April 2011, Melbourne, p. 22.

185 See the Mindful Employer program website for details: http://www.mindfulemployer.org/sane

186 Ms Barbara Hocking, CEO, SANE Australia, *Committee Hansard*, 13 April 2011, Melbourne, p. 22.

187 Ms Barbara Hocking, CEO, SANE Australia, *Committee Hansard*, 13 April 2011, Melbourne, p. 23.

review the licensing arrangement.[188] This includes talks with government departments. SANE Australia noted that Centrelink had shown an interest.[189] SANE Australia also indicated that is working in partnership with the Australian Human Resources Institute to develop and pilot learning modules to present to workplaces that are already very interested.[190]

Employer advocates

3.198 SANE Australia and others, including Mental Illness Fellowship Victoria and Orygen Youth Health, endorsed the role that employee advocates, like disability employment providers and employment consultants, play in assisting a job seeker with a mental illness to enter and maintain employment.[191]

3.199 SANE Australia noted:

> the specialist employment agencies are so important because their role is to find the right job for the right skills and the right person.[192]

3.200 Ms Collister, General Manager, Rehabilitation Services, Mental Illness Fellowship Victoria said of:

> The employment consultant – an individual approach is absolutely critical in making a relationship with the employer.[193]

3.201 Many employers need a go-to-person as much as employees for advice on how best to assist their employees. Employers can obtain assistance through a range of means, by calling government hotlines like JobsAccess or Jobs in Jeopardy, their organisation's EAP, and advocacy or peak bodies like Sane Australia, Beyond Blue or Australia Psychological

188 Ms Barbara Hocking, CEO, SANE Australia, *Committee Hansard*, 13 April 2011, Melbourne, p. 23.

189 Ms Barbara Hocking, CEO, SANE Australia, *Committee Hansard*, 13 April 2011, Melbourne, p. 276.

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191 See for example Ms Barbara Hocking, CEO, SANE Australia, *Committee Hansard*, 13 April 2011, Melbourne, p. 24, Ms Laura Collister, General Manager, Rehabilitation Services, Mental Illness Fellowship Victoria, *Committee Hansard,* 13 April 2011, Melbourne, p.p. 4-7, Ms Gina Chinnery, Youth Employment Consultant, Youth Orygen Health, Committee Hansard, 13 April 2011, Melbourne, pp. 12-21.

192 Ms Barbara Hocking, CEO, SANE Australia, *Committee Hansard*, 13 April 2011, Melbourne, p. 24.

193 Ms Laura Collister, General Manager, Rehabilitation Services, Mental Illness Fellowship Victoria, *Committee Hansard,* 13 April 2011, Melbourne, p.7.

Society. They can also call upon employer associations like chambers of commerce for advice.

3.202 Ms Marcia Kuhne, Manager, Industrial Relations Policy, CCI WA reported an increase over the past two years in contact from employers seeking advice on how to deal with employees manifesting mental health issues.[194]

3.203 According to Comcare, it is a misnomer that employers are reticent about this issue and seeking help. In their experience, the opposite is true:

> Our employers, big business are very aware of this problem....that it hits their bottom line, that they need to invest in their people and they are very committed to better outcomes and they come knocking on our door.[195]

3.204 Ms Kuhne said the Chamber suggested to members that 'it is appropriate that they seek advice from experts as to how [those issues be] managed.'[196]

3.205 The Australian Human Rights Commission recommended that 'diversity field officers' be located in various industry groups and associations across Australia:

> ...as many employers feel more comfortable contacting someone known to them in the first instance to ask specific questions about employment and disability.[197]

3.206 While this is a matter of resourcing for those organisations, it is worth recalling ACCI's commendation of the benefits to their organisation of having a dedicated officer to facilitate workforce participation for mature-aged employees, and the extrapolation that similar benefits might extend if a dedicated officer were to be employed to facilitate greater workforce participation of employees with mental ill health.

Targeted and multi-faceted workplace solutions

3.207 The following sections highlight the creative, practical and collaborative approaches that some organisations are taking, in integrating advice from experts into their human resources and organisational practices. These

194 Ms Marcia Kuhne, Manager, Industrial Relations Policy, CCI WA, *Committee Hansard*, 18 October 2011, Perth, p. 1.

195 Mr Neil Quarmby, Director, Work Health, Comcare, *Committee Hansard*, 14 October 2011, p. 37.

196 Ms Marcia Kuhne, Manager, Industrial Relations Policy, CCI WA, *Committee Hansard*, 18 October 2011, Perth, p. 1.

197 AHRC, *Submission 44*, p.5.

strategies are characterised by being targeted, multi-faceted and comprehensive. Such visionary approaches exemplify directions that employers might take to achieve better employment and retention of workers with mental ill health.

3.208 Ms Susan Robertson, Managing Director, Edge Employment Solutions, the largest disability employment service in Western Australia, emphasised that the majority of jobs secured for clients are in large businesses and the public sector (62 per cent combined). In her view, these two sectors offer good human resources practices for employees with a mental illness because of:

> good training and development opportunities, opportunities for career enhancement, good support in terms of the range of co-workers that work around that person in employment, and the range of tasks that can be brought together to construct a suitable job for a person with mental health issues.[198]

3.209 Ms Robertson said that jobs in the public sector and large businesses tended to have the best long term employment prospects for Edge clients, with an average tenure of 17.34 months in the public sector, followed by 14 months in large business.[199]

3.210 The remainder of this chapter will outline the approach of one public sector organisation, the Department of Defence and two large businesses, Abigroup Construction and Rio Tinto.

Public sector to lead by example

3.211 National Disability Services and others called for the Government to 'lead by example' to improve public sector employment of people with a disability. According to NDS:

> The public service employment rate of people with a disability at 3.1 per cent is the lowest in over a decade...and significantly lower than the proportion of people with disability within the population (20 per cent).[200]

3.212 Mrs Melissa Williams, Manager, Gold Coast Employment Services, made the same call to all levels of government, including local government:

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198 Ms Susan Robertson, Managing Director, Edge Employment Solutions, *Committee Hansard,* 18 October 2011, Perth, p. 22.

199 Ms Susan Robertson, Managing Director, Edge Employment Solutions, *Committee Hansard,* 18 October 2011, Perth, p. 22.

200 National Disability Services, *Submission 35*, p. 7.

> Government at all levels needs to lead by example in employment of people with psychiatric disabilities and they all have a very, very poor track record. We have tried and tried and tried to get into our local council here and we get knocked back, without going into all our different attempts.[201]

3.213 The Australian Human Rights Commission agreed and recommended that the Commonwealth Government develop a strategy to increase public sector employment of people with a disability. Suggested measures to achieve this include:

- a proportion of public service graduate recruitment places are reserved for graduates with disability…
- recruitment targets for employees with disability are set by all public sector agencies. As an example, the ACT Government recently launched the ACT Public Service Employment Strategy which includes a target to double the number of public servants with disabilities over the next four years;
- creation of apprenticeship, traineeship and work experience opportunities for people with disability;
- recruitment agencies contracted by APS agencies, as a requirement of their contract, are encouraged and supported to identify applicants with disability; and
- the development of a comprehensive support and capacity building programme for employees with disability and their public sector employers. This could include:
  - ⇒ a specific pool of funds for training opportunities for employees with disability;
  - ⇒ all employees with disability to be given the opportunity to be matched with a mentor during their term of employment.[202]

3.214 National Disability Services noted rules, effective from 2010, intended to make it easier for Australian Public Service (APS) agencies to employ someone with a disability. These include disability employment service providers assisting the employer by offering ongoing support to the employee:

> The compulsory use of a disability employment service provider when employing a person with disability relieves government agencies of the need to develop their own expertise in assessing

201 Mrs Melissa Williams, Manager, Gold Coast Employment Service, *Committee Hansard*, 8 August 2011, p. 13.

202 Australian Human Rights Commission, *Submission 44*, p. 5.

> the capability of a prospective employee, in designing and modifying a position to suit their capability and in providing ongoing support if required.[203]

Comcare

3.215 Comcare implements Commonwealth Government policies in federal workplaces and administers the Comcare scheme, which provides access to compensation for eligible injured workers.[204]

3.216 Mr Neil Quarmby, General Manager, Work Health and Safety Group, Comcare noted that in addition to covering all the government departments and agencies, Comcare is a broad ranging scheme, that, for instance, includes 30 self-insurers, namely big private companies that have opted into the system:

> We have a number of the big banks such as Commonwealth Bank. We have 80 per cent of the line-haul transport systems, the big companies, Linfox, K&S Freighters for example.[205]

3.217 Comcare indicated that one of its priorities is improving the mental health, wellbeing and resilience of workers in the Comcare scheme and to tackle the problem of psychological injury resulting from stress in the workplace, because:

> Mental health is becoming a major cause of disability in the scheme with serious productivity consequences for employers.[206]

3.218 Comcare reported that workers' compensation claims together with the costs of treating psychological conditions has risen in recent years, especially in the Australian Public Service (APS) where in figures to 30 June 2010:

- around 11 per cent of all accepted claims within Australian Government premium payers involved mental disease as either a primary or secondary condition; and
- around 43 per cent of the total cost of accepted claims related to these claims.[207]

3.219 While Comcare speculated some of the reasons for this increase might include an increased awareness in the community about mental health

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203 National Disability Services, Submission 35, p. 7.

204 See Comcare website for details: http://www.comcare.gov.au/about_us

205 Mr Neil Quarmby, General Manager, Work Health and Safety Group, Comcare, *Committee Hansard*, 14 October 2011, p. 37.

206 Comcare, *Submission 62*, p. 1.

207 Comcare, *Submission 62*, p. 2.

and general pressures resulting from modern day living, 'the drivers for this increase are as yet unknown.'[208]

3.220 In recognition of the large numbers of people affected and in an attempt to reverse the trend, Comcare stated that it has:

> shifted to a more proactive mode. In the past our system, like other similar jurisdictions, operated in a very reactive mode so you wait for the individual to get hurt; then you try to support them, work on their compensation and you investigate and tell the employer what they should have done to stop that person getting hurt in the first place. Through our 2015 strategic plan...we have largely shifted away to operate more fundamentally in a preventative capacity working with employers, the unions, employees, practitioners and a range of support people to actually build a work environment where health is promoted and harm is prevented.[209]

3.221 Comcare described its approach:

> We have been working very closely with employers in our scheme. We have a range of resources. We have line management training in mental health. We are also seeking to move further upstream...to try to create work environments that enable people with mental illness to stay in employment because, whilst there has been a lot of discussion around seeking to get people at the threshold of entering employment, there is huge capacity to really be creating workplaces that are more proactive in responding to enable people to stay at work with mental illness rather than falling out of employment or into the compensation system and being able to prevent that unnecessary disability and work loss that results from people leaving.[210]

3.222 Comcare cited its Centre for Excellence in Mental Health and Wellbeing, which was established to provide strategic and practical strategies to improve mental health at work. [211]The Centre has an Advisory Group of

208 Comcare, *Submission 62*, p. 1.

209 Mr Neil Quarmby, General Manager, Work Health and Safety Group, Comcare, *Committee Hansard,* 14 October 2011, p. 35.

210 Mr Neil Quarmby, Director, Work Health, Comcare, *Committee Hansard*, 14 October 2011, p. 37.

211 Comcare, *Submission 64,* Attachment A, p. 6.

experts that includes Associate Professors Eoin Killackey and Peter Butterworth.[212]

3.223 Comcare's criteria for workplaces that support mental health and wellbeing are:

- workplaces demonstrate a focus on mental health and work by establishing principles that are integrated into work design, people management practices, business processes, leadership and staff development programs;
- workplaces assess the risks to mental health and wellbeing and take action to continuously improve culture and systems at work;
- managers have capability and support to help workers adapt to challenge and change and are held accountable for this work;
- the work community is able to recognise early warning signs and people have the confidence and avenues to respond to mental ill health at work'
- managers seek to understand issues that may impact on individual's ability to work and make adjustments to accommodate this;
- people at work are involved in decisions on how their work is undertaken, including changes that affect them directly;
- people at work have guidelines, tools and support for performance improvement and are accountable for their behaviours;
- mental health and rehabilitation service are evidence based, improve functioning and foster participation in work;
- people with longer term incapacity for work due to mental ill health are offered pathways back to employment;
- injured workers experience of the compensation process is supportive and not detrimental to mental health; and
- injured workers' have access t o information and support to optimise their involvement in recovery and return to work.[213]

3.224 Ms Christine Bolger, Director, Work Care, Comcare pointed to the importance of the Centre and these criteria:

> I think that gives a really strong direction on characteristics of work and the type of line management support and assistance that is needed to keep people working.[214]

212 See Comcare website for details: http://www.comcare.gov.au/safety__and__prevention/work_health/prevent/centre_of_excellence_advisory_group_members

213 Comcare, *Submission 64*, Attachment A, p. 6.

214 Ms Christine Bolger, Director, Work Care, Comcare, *Committee Hansard*, 14 October 2011, p. 40.

3.225 Ms Bolger added that the Centre intends to draw on the breadth of community practice that is already there, rather than 'reinvent the wheel'. She said:

> Comcare has linkages with the ANU and a lot of the service providers in this area as well.[215]

3.226 The principles of prevention and early intervention, espoused by Comcare, and the importance of collaborative partnerships underpin the following case-studies.

Department of Defence

3.227 The Department of Defence is the largest Commonwealth Government agency. It consists of 84,000 members of the Australian Defence Force and 23,000 civilian public service employees.[216]

3.228 Major General Fogarty, Head, People Capability stated that Defence had undergone a huge organisational shift in recent years. He observed:

> Attitudes towards mental health in our department have changed significantly over the last five to seven years, for example, great emphasis is now placed on keeping our people, not discharging them.[217]

3.229 Mr David Morton, General Manager, Mental Health, Psychology and Rehabilitation concurred:

> We have addressed this issue about discharge. We have taken that fear away.
>
> Still being able to be deployed whilst you are rehabilitating or being treated is another big, important part.[218]

3.230 Major Fogarty stated:

> We view psychological injury as an occupational hazard and it is therefore contemplated by our Defence OH&S management system. Our system has 17 elements, including notification, treatment, rehabilitation and compensation, and this covers both

215 Ms Christine Bolger, Director, Work Care, Comcare, *Committee Hansard*, 14 October 2011, p. 40.

216 Major General Fogarty, Head, People Capability, Department of Defence, *Committee Hansard,* 14 October 2011, Canberra, p. 20.

217 Major General Fogarty, Head, People Capability, Department of Defence, *Committee Hansard,* 14 October 2011, Canberra, p. 20.

218 Mr David Morton, General Manager, Mental Health, Psychology and Rehabilitation, Department of Defence, *Committee Hansard*, 14 October 2011, p. 23.

> the APS employees as well as the ADF members. We also maintain a comprehensive fairness and resolution framework that recognises the importance and the value of diversity and equity in all our workplaces within Defence.[219]

3.231 While some initiatives are relevant to both civilian and military workforces, such as suicide awareness and drug and alcohol issues training, Major Fogarty described other programs that are designed specifically for the ADF component. One such program is called BattleSMART – a self-management resilience training regime for high stress operations environments.[220] Complementing BattleSMART is a trial of the FamilySMART program which recognises that families are also an important part of the equation.[221]

3.232 Major Fogarty referred to Defence's development of a psychological health strategy for its civilian arm to reduce the incidence and severity of work related psychological injury.[222]

3.233 Mr Neil Tomkin, First Assistant Secretary, Defence People Solutions, Department of Defence noted that there has been an increase in the number and cost of psychological illness and injury in recent years:

> we have seen an increase from 2007, with 12 per cent of accepted compensable claims being for mental stress rising to over 14 per cent in more recent years...in 2010, there [was] a substantial increase to an average [cost] of $216, 000.[223]

3.234 Defence is keen to reverse this trend and its attendant loss in productivity. The Department has prepared and disseminated a range of educational materials to guide managers, supervisors and human resources practitioners as part of its focus on prevention and early intervention. A complementary pro-active intervention program comprises:

> Early Case Management Assessment Tool called ECMAT)...[that] provides an ongoing commitment to high-risk case managing between Defence case managers and Comcare claims

219 Major General Gerhard Fogarty, Head, People Capablity, Department of Defence, *Committee Hansard,* 14 October 2011, Canberra, p. 20.

220 Major General Gerhard Fogarty, Head, People Capablity, Department of Defence, *Committee Hansard,* 14 October 2011, Canberra, p. 20.

221 Mr David Morton, General Manager, Mental Health, Psychology and Rehabilitation, Department of Defence, *Committee Hansard*, 14 October 2011, p. 23.

222 Major General Gerhard Fogarty, Head, People Capablity, Department of Defence, *Committee Hansard,* 14 October 2011, Canberra, p. 20.

223 Mr Neil Tomkins, FAS, Defence People Solutions, Defence, *Committee Hansard*, 14 October 2011, Canberra, p. 21.

> managers...MD guideline licenses for our case managers [so they have access to the latest evidence based clinical guidance]...and a strategic intervention team to manage the most complex medical and rehabilitation cases.[224]

3.235 Mr David Morton, General Manager, Mental Health, Psychology and Rehabilitation, Defence, described the ADF's mental health reform program, following the 2009 Dunt Mental Health Review which identified some gaps.[225] The adoption of a new 'continuum of care' approach:

> Supports capability through mental fitness and takes a positive approach to the notion of mental health whilst recognising that we reduce the stigma that prevents people from identifying themselves early enough to seek treatment.[226]

3.236 As a response to the Dunt report recommendations, a dedicated mental health psychology and rehabilitation branch has been established to integrate the program at a national level. Mr Morton advised that there had been a number of additional appointments at Joint Health Command to bring into being their new integrated approach:

> We get an integrated approach by putting our mental health professionals, our rehab professionals, into the primary healthcare teams and in that way trying to achieve a breakdown in stigma...so somebody is presenting to the one service...so that you are taking a whole-of-person look at the situation.[227]

3.237 Other key elements of the Defence approach include the use of peer support programs, identifying champions willing to talk about their experiences in overcoming mental illness and successful navigation through rehabilitation programs, and, perhaps, most importantly, reframing the language used to talk about mental health, from having negative and weak connotations to positive and strong ones:

> The notion of leading the discussion around, 'We want you to come forward and tell us about your mental health problems, 'is a bit of a downer. You heard me before start to use the term 'mental fitness'. To encourage command and encourage middle and junior

224 Mr Neil Tomkins, FAS, Defence People Solutions, Defence, *Committee Hansard*, 14 October 2011, Canberra, p. 21 and p. 26.

225 The report is available from the Defence website: http://www.defence.gov.au/health/DMH/Review.htm viewed 13 February 2012.

226 Mr David Morton, General Manager, Mental Health, Psychology and Rehabilitation, Department of Defence, *Committee Hansard*, 14 October 2011, p. 22.

227 Mr David Morton, General Manager, Mental Health, Psychology and Rehabilitation, Department of Defence, *Committee Hansard*, 14 October 2011, p. 22.

> leadership to start recognising that mental fitness is as important as physical fitness you start to then get a different balance opportunity created there.[228]

3.238 Mr Morton emphasised how important it is to integrate this positive language into a command structure. Commanders' understanding and belief in the message that, 'you can do something about this; it is about recovery' is integral to the message trickling down and through the organisation. Mr Morton indicated this was happening and supported by senior leadership in Defence.[229]

3.239 In line with a proactive approach, Major Fogarty concluded by saying that, 'We are continuing to test, evaluate and adjust.'[230]

3.240 Mr Tomkins said Defence had been pleased with the level of collaboration it had undertaken with Comcare in respect of mental health promotion but noted that more collaborative work in this area is required:

> Our concern has been that, as the employer we can do more through collaborative work between agencies to help employees.[231]

Private sector to lead by example

3.241 Like the public sector, the private sector should lead by example too. Mr Tawanda Machingura, Assistant Director of Occupational Therapy, Gold Coast Health Service, Queensland Health said:

> One of the things I think would be useful if employers talking to other employers or talking about some of those good stories in the media-about how some of their employees who have a mental illness have done so well. I hope that will go a long way in reducing stigma in our community.[232]

3.242 The following companies do just this.

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228 Mr David Morton, General Manager, Mental Health, Psychology and Rehabilitation, Department of Defence, *Committee Hansard*, 14 October 2011, p. 24.

229 Mr David Morton, General Manager, Mental Health, Psychology and Rehabilitation, Department of Defence, *Committee Hansard*, 14 October 2011, p. 24.

230 Major General Fogarty, Head, People Capability, Department of Defence, *Committee Hansard,* 14 October 2011, Canberra, p. 24.

231 Mr Neil Tomkins, FAS, Defence People Solutions, Defence, *Committee Hansard*, 14 October 2011, Canberra, p. 26.

232 Mr Tawanda Machingura, Assistant Director of Occupational Therapy, Gold Coast Health Service, Queensland Health, *Committee Hansard*, 8 August 2011, pp. 23-24.

Abigroup Inc.

> We have essentially normalised the discussion...It is just like any other physical injury that people would want to talk about....as soon as you make the space safe and comfortable for [people] to talk, they talk....I am not going to sit here and say that there is not still a stigma that exists in our organisations – it still does, in pockets – but we are slowly chipping away.[233]

3.243 Ms Sarah Marshall, National Environmental and Sustainability Manager, Abigroup sketched the scope of Abigroup's business, to set the scene:

> Abigroup is one of Australia's leading and most diverse national construction contractors. We have over 50 years experience in roads, rails, buildings, mining, tunnels, bridges, energy and communications across Australia. We are part of the Lend Lease Group, and we have offices across Australia....It owns and operates one of the largest plant equipment fleets in the southern hemisphere, operates its own precast yards and has its own in-house expertise and blue collar work force...Abigroup has 3000 employees...Of those employees, 83 percent are male.[234]

3.244 Abigroup signed a memorandum of understanding with Beyondblue in 2010 to develop a DVD of the lived experience of depression and anxiety disorders in the construction industry that could be used by Abigroup and others in the construction industry. [235]

3.245 The collaboration came about following a workshop with Abigroup directors and managers in 2008 who saw a need for increased awareness in the workforce and wanted to encourage their workers to seek help early but had not come across any material to-date that seemed tailored to their industry:

> The construction industry is a unique industry and has a very strong culture and we could not find in all of the evidence or material we were looking at anything that really talked to our industry...to the culture and the male dominated workforce that we have.

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233 Ms Sarah Marshall, National Environmental and Sustainability Manager, Abigroup Ltd, *Committee Hansard*, 9 August 2011, Brisbane, p. 37.

234 Ms Sarah Marshall, National Environmental and Sustainability Manager, Abigroup Ltd, *Committee Hansard*, 9 August 2011, Brisbane, p. 36.

235 Ms Sarah Marshall, National Environmental and Sustainability Manager, Abigroup Ltd, *Committee Hansard*, 9 August 2011, Brisbane, p. 36.

> So we developed our own. We tailored the Beyondblue national workforce program for delivery to workers in Abigroup construction sites as a pilot....as well as delivering the existing national workplace program to over 600 Abigroup office-based staff.[236]

3.246 The DVD called 'Building Strong Foundations' features four case-studies of male employees in different jobs within the organisation (a bricklayer, engineer, foreman and union official), spanning their 20s, 30s and 70s, talking about their experiences of living with a mental illness, the problems they had had at work and how they sought help to get better.

3.247 Mr Rhett Foreman, a General Foreman at Abigroup, who appears on the DVD relayed why he had volunteered to be part of the DVD:

> Putting yourself out there – and my family were in it...is a pretty bold step...But I thought: You've got to put your hand up...it's getting the message out and helping other people - and the construction industry certainly needs it.[237]

3.248 The DVD has been an enormous success. According to Mr Foreman:

> The feedback has been overwhelmingly positive...the main thing is it empowers people to put their hand up and they do not feel like they are on their own.[238]

3.249 The DVD is used in different ways. There is a shorter version, a 7 minute promo used in employee inductions and the longer DVD is played on loop-play in crib sheds. Mr Foreman described the DVD as a sort of conversation starter 'the DVD is the key in the door...and it has raised a lot of awareness.'[239]

3.250 Abigroup also described collaboration with Mates In Construction, Boystown and Movember. Mates In Construction (MIC) is a Queensland based organisation, supported by Queensland Health and others established to raise awareness about suicide and mental health amongst building and construction workers.

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236 Ms Sarah Marshall, National Environmental and Sustainability Manager, Abigroup Ltd, *Committee Hansard*, 9 August 2011, Brisbane, p. 36.

237 Mr Rhett Foreman, General Foreman, Abigroup, *Committee Hansard*, 9 August 2011, Brisbane, p. 37.

238 Mr Rhett Foreman, General Foreman, Abigroup, *Committee Hansard*, 9 August 2011, Brisbane, p. 37.

239 Mr Rhett Foreman, General Foreman, Abigroup, *Committee Hansard*, 9 August 2011, Brisbane, p. 40.

3.251 The MIC suicide prevention program was developed because of the concern that up to one in twenty construction workers will contemplate suicide during any given year. The program provides general suicide awareness and training for construction site workers as well as ongoing support for trained on-site 'connectors' (identified with a sticker on their hardhat) whose role is to identify at risk workers and link them to MIC case managers as well as facilitate on-site mental health and well-being events.[240]

3.252 Mr Foreman praised MIC's general awareness training on suicide and having MIC connectors on Abigroup sites. He explained how it works in practice:

> We had a guy come to our office at six o'clock the other morning when all us managers were talking and he said, 'I want to talk about some issues.' ...He left in a huff and the boss said, 'See if you can grab him.' I said, 'Come in here, come into my office, here is the Mates in Construction 1300 number. Talk to them, I'll leave you alone for a while and then we'll have a chat. I went off and grabbed one of the connectors...and he talked to the guy and his boss was very supportive and then the guy was okay after about an hour, he went to work, went to some counselling.[241]

3.253 The success of the program lies in what Mr Foreman describes as 'coming at the issues at different angles'. The DVD is one component, having MIC connectors on site is another (so far this has been happening only in Queensland but Abigroup is considering rolling out the program nationally). Ms Marshall summarised her approach to mental health training:

> If you had someone who fell over and sprained their wrist or ankle [at work] about one in five would know what to do...My approach is that...if we have one in five out of our workforce that knows, 'This is looking like a mental health problem, starting to see some changes in their behaviour, this is what I am going to do, I am going to direct them to help that is our approach.[242]

3.254 Perhaps at the heart of Abigroup's success is recognition and ownership from management that mental health is a common issue amongst

240 For more information about Mates in Construction see Submission 60 and the website, http://www.matesinconstruction.com.au/

241 Mr Rhett Foreman, General Foreman, Abigroup, *Committee Hansard*, 9 August 2011, Brisbane, p. 41.

242 Ms Sarah Marshall, National Environmental and Sustainability Manager and Mr Rhett Foreman, Foreman, Abigroup, *Committee Hansard*, 9 August 2011, Brisbane, p. 40.

employees, that it is something they address in a number of ways, as part of the regular working day. Mr Foreman mentioned how impressed he had been at his job interview for Abigroup, when in the waiting room he had read an article in the company newsletter about management presenting a sum of money to Beyondblue. He said this emboldened him to reveal in the job interview that he had himself suffered mental illness. He stated:

> I thought, 'If you're putting this in a national newsletter and leaving that down at front reception for people to read, you've obviously put a lot of thought into it and there's a really good culture behind that.[243]

Rio Tinto and Dampier Salt

> The vast majority of our employment process is around the individual's capability to do the job, irrespective of their physical or mental health capacity.[244]
>
> A classic example is that we employ a lot of people who are ex-ADF [some of whom have post-traumatic stress disorder]...Typically they are very good leaders with very good skills. Yes, sometimes things that will happen that will trigger problems for them that we have to manage, and it is far easier to manage those situations if we know about them...we can work with them....so they can continue to be a valued employee.[245]
>
> Our general situation is the same whether it is mental health or physical health.[246]

3.255 Rio Tinto establishes mines and processes mineral resources. In addition to a strong presence in Australia and North America, the company has significant businesses in Asia, Europe, Africa and South America. Rio Tinto has some 70,000 employees, 20,000 of whom are in Australia.[247]

3.256 Rio Tinto is the leading iron ore exporter in Australia (and the second largest in the world). Rio Tinto's iron ore operations are concentrated in the Pilbara region of Western Australia where annual capacity stands at 225 million tonnes, with plans to expand. [248]

243 Mr Rhett Foreman, Abigroup, *Committee Hansard*, 9 August 2011, Brisbane, p. 37.
244 Ms Denise Goldsworthy, CEO, Dampier Salt, *Committee Hansard*, 18 October 2011, Perth, p. 10.
245 Ms Denise Goldsworthy, CEO, Dampier Salt, *Committee Hansard*, 18 October 2011, Perth, p. 10.
246 Ms Denise Goldsworthy, CEO, Dampier Salt, *Committee Hansard*, 18 October 2011, Perth, p. 10.
247 Rio Tinto, *Submission 67*, p. 1
248 Rio Tinto, *Submission 67*, p. 1

3.257 Dampier Salt (DSL), a member of the Rio Tinto Group, is the world's largest solar salt producer, producing in excess of 10 million tonnes each year. DSL has two operations in the Pilbara (Dampier and Port Hedland) and one in the Gascoyne region (Lake Macleod) of Western Australia.[249] Dampier Salt has 506 employees.[250]

3.258 Rio Tinto Group recognises mental health is a workforce issue, with the potential to impinge on workers' safety performance, employment costs and productivity, both directly and indirectly.'[251]

3.259 Rio Tinto detailed the range of supports it typically offers to employees and their families if an employee is suffering from a mental illness:

> This includes the provision of EAPs and opportunities for staged return to work rehabilitation programmes. Rio Tinto's The Way We Work sits at the centre of policy, and ensures that all Rio Tinto businesses ensure that all people are given opportunities for training and success in their role, free of discrimination and harassment.[252]
>
> We provide them with general awareness training...and training on [how to access the EAP program].[253]

3.260 Broader health and safety strategies and programs include:

- wellness programs targeting fatigue management, sleep screening, health risk assessments, health campaigns and social activities;
- health insurance assistance in the form of a medical subsidy;
- family engagement opportunities such as Fly In Fly Out family visits to site, family recreation passes; and
- policies and procedures ie. bullying and drug and alcohol policy.[254]

3.261 In addition , Rio Tinto:

> supports on the ground health-related initiatives such as the development of the Paraburdoo Men's Shed, youth programmes and providing in-kind accommodation for counselling services.[255]

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249 Rio Tinto, *Submission 67*, p. 1

250 Dampier Salt website, http://www.dampiersalt.com.au/index_operations.asp

251 Rio Tinto, *Submission 67*, p. 1

252 Rio Tinto, *Submission 67*, p. 1

253 Ms Denise Goldsworthy, CEO, Dampier Salt, *Committee Hansard,* 18 October 2011, Perth, p. 12.

254 Rio Tinto, *Submission 67*, p. 4.

255 Rio Tinto, *Submission 67*, p. 3.

3.262 Dr Andrew Porteous, Manager, Corporate Health and Safety, Rio Tinto said that mental health issues had traditionally received little attention in the mining industry and the nature of support had been 'primarily reactive'. [256]

3.263 However, as Rio Tinto continues to expand operations and there is 'fierce competition for personnel' in the mining sector, the company is increasingly:

> Committed to finding new ways to help our workforce manage mental health and resilience by building and sustaining a supportive and health working culture.[257]

3.264 Dr Goldsworthy, CEO of Dampier Salt agreed and confirmed senior management's commitment to these policies.[258]

3.265 Dr Porteous referred to Rio Tinto's and Dampier Salt's adoption of the UK Health and Safety Executive's *Management Standards for Workplace Stress*[259] as a basic for some of the company's approaches to mental health.[260]

3.266 Ms Denise Goldsworthy, CEO, Dampier Salt described the Mental Health Strategy Pilot's overall aim:

> To bring a more holistic approach to mental health care to ensure its inclusion in induction and training programs and to integrate mental health into occupational health and safety policies and practices.[261]

3.267 Ms Goldsworthy indicated that while there have been some successes with the company's reactive support programs, the group believes it can do better:

> While Rio Tinto's proactive mental health strategies are only in their initial stages, they are the first step towards achieving better outcomes for our employees through supporting them to increase their resilience to mental illness or to manage their illnesses in a more integrated way.[262]

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256 Dr Andrew Porteous, Manager, Corporate Health and Safety, Rio Tinto, *Committee Hansard,* 18 October 2011, Perth, p. 7.

257 Rio Tinto, *Submission 67*, p. 1.

258 Ms Denise Goldsworthy, CEO, Dampier Salt, *Committee Hansard,* 18 October 2011, Perth, p. 9.

259 Health and Safety Executive, Management Standards for work related stress, http://www.hse.gov.uk/stress/standards/

260 Rio Tinto, *Submission 67*, p. 3.

261 Ms Denise Goldsworthy, CEO, Dampier Salt, *Committee Hansard,* 18 October 2011, Perth, p. 8.

262 Ms Denise Goldsworthy, CEO, Dampier Salt, *Committee Hansard,* 18 October 2011, Perth, p. 8.

3.268 She said that the pilot presents a unique opportunity for the company to look at mental health in a mining workforce, seek to identify and address organisational factors which may contribute to reduced mental health – and to potentially feed those lessons from a smaller business back into the larger Rio Tinto Group.[263]

3.269 Rio Tinto hopes that, resulting from this approach, employees will be better able to recognise mental health problems in themselves and each other and have enhanced access to mental health support if needed. Such a strategy might also contribute to:

> Improved morale...increased workforce stability with higher retention rates; reduced absenteeism...improved status as a preferred employer...and improved production and profitability.[264]

3.270 Ms Goldsworthy outlined how the pilot will work. Commencing in late 2011 and running for three years the project comprises four phases:

> Commitment, consultation, engagement and maintenance followed by a well-defined evaluation and review process.[265]

3.271 To date, some baseline data has been collected which indicates areas of strength and weakness:

> the sorts of areas of strength that have been identified include...realistic work expectations...and on the job peer-support...
>
> At the other end of the scale, opportunities for improvement include more training for our front-line supervisors...and improved means for accessing flexible work practices.[266]

3.272 Rio Tinto emphasised that it is seeking a collaborative approach to change and to work together with a range of partners to increase community awareness and reduce the stigma associated with mental illness. These partners might include governments, health professionals and private industry.

3.273 In addition to working to redress the shortages of health professionals in regional Australia Ms Goldsworthy suggested:

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263 Ms Denise Goldsworthy, CEO, Dampier Salt, *Committee Hansard,* 18 October 2011, Perth, p. 8.
264 Ms Denise Goldsworthy, CEO, Dampier Salt, *Committee Hansard,* 18 October 2011, Perth, p. 8.
265 Ms Denise Goldsworthy, CEO, Dampier Salt, *Committee Hansard,* 18 October 2011, Perth, p. 8.
266 Ms Denise Goldsworthy, CEO, Dampier Salt, *Committee Hansard,* 18 October 2011, Perth, p. 9.

> television and radio campaigns...and sponsorship of conferences or workshops where specialists can talk to employers as well as where employers can share best practice.[267]

Australasian Centre for Remote and Rural Mental Health

3.274 One of Rio Tinto's major partners is the Australasian Centre for Remote and Rural Mental Health (ACRRMH). They outlined their role in the Dampier Salt pilot:

> this pilot was proposed and is being facilitated by the Australasian Centre using the Centre's mental health roadmap for the mining and resources centre.[268]

3.275 Dr Jennifer Bowers, CEO, Australasian Centre for Rural and Remote Mental Health (the Centre) detailed the Centre's commitment to practical mental health and wellbeing outcomes in regional and remote Australia, with a focus on helping those who work in the mining and resources sector, where she says understanding has to date been, at best 'embryonic.'[269]

3.276 The Centre organised two seminal forums in Coolum and Perth to raise greater awareness in the mining sector of the impact of mental health on productivity and profit. Dr Bowers observed that the forums were attended not only by senior mining executives, but also mental health professionals, indigenous representatives, communication experts and researchers. Mining companies and the WA Government came on board:

> As a result of these forums the Centre began work with three mining businesses on the development of mental health strategies. The Centre was engaged by the Western Australian Department of Mines and Petroleum to work with their mine safety inspectors on mental health.[270]

267 Ms Denise Goldsworthy, CEO, Dampier Salt, *Committee Hansard,* 18 October 2011, Perth, p. 9.

268 Dr Jennifer Bowers, Australasian Centre for Rural and Remote Mental Health, *Committee Hansard,* 24 November 2011, Canberra, p. 2.

269 Dr Jennifer Bowers, Australasian Centre for Rural and Remote Mental Health, *Committee Hansard,* 24 November 2011, Canberra, p. 2.

270 Dr Jennifer Bowers, Australasian Centre for Rural and Remote Mental Health, *Committee Hansard,* 24 November 2011, Canberra, p. 2.

3.277 Like other witnesses, Dr Bowers referred to the varying success of reactive strategies to mental health in the workplace like EAPs and general awareness-building programs.[271]

3.278 By contrast, the Centre works with the mining and resources sector to design individualised mental health 'road maps' for organisations:

> Long-term partnerships in which, together, we develop, implement and monitor whole-of-business mental health strategy which incorporates recruitment, induction, human resources and occupational health and safety policies and practices.[272]

3.279 In practice this means focusing on primary and secondary interventions which are by their nature, inherently, more proactive. She explained:

> In a primary intervention the Centre uses a series of devices and techniques to make mental health a safe topic in the workplace and/or social community context. These devices can include musical performances, art based activities, brochures, on-site consultations, forums, informal workshops and discussions...secondary interventions are characterised by more formal workshops, presentations, briefings and review of policies, along with...posters, booklets and discreet, wallet-sized helpline and website cards. The centre has also designed a lifestyle and well-being survey...to target new interventions.[273]

3.280 According to Dr Bowers, research unanimously supports primary and secondary interventions as providing greater cost-effectiveness to businesses than tertiary interventions. She cited a UK report:

> That even a small shift in expenditure from treatment to prevention promotion generated very significant energy gains and a broad range of payoffs and benefits that lasted for many years.[274]

3.281 Entrenched cultural and attitudinal changes in the workplace are not easily overcome. Dr Bowers stressed the importance of sustained commitment from the top down in overcoming a head-in–the-sand approach:

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271 Dr Jennifer Bowers, Australasian Centre for Rural and Remote Mental Health, *Committee Hansard,* 24 November 2011, Canberra, p. 2.

272 Dr Jennifer Bowers, Australasian Centre for Rural and Remote Mental Health, *Committee Hansard,* 24 November 2011, Canberra, p. 2.

273 Dr Jennifer Bowers, Australasian Centre for Rural and Remote Mental Health, *Committee Hansard,* 24 November 2011, Canberra, p. 2.

274 Dr Jennifer Bowers, Australasian Centre for Rural and Remote Mental Health, *Committee Hansard,* 24 November 2011, Canberra, p. 3.

> It does need commitment, as has been demonstrated in the companies we are working with, from the top, and it needs leadership...and some ability for people to engage down the line.[275]

3.282 Dr Bowers enthused about the interest and commitment that she is seeing in the mining industry. She praised the leadership of the Department of Mines and Petroleum in Western Australia and all the mining companies from across Western Australia who participated in and actively contributed to presentations and exercises during a recent road show throughout WA:

> The anecdotes and stories that we received on the ground were quite moving, and, on the other hand, motivating.[276]

Discovering and sharing best human resources practice

3.283 Targeted, integrated and comprehensive programs that look after the mental health of all employees, such as those undertaken by organisations like Defence, Abigroup and RioTinto, exemplify progressive ways forward for employers and employees alike.

3.284 Despite their different business focuses, public sector (operational and civilian) versus private sector (construction and resources), what these organisations all have in common is the implementation of proactive strategies, policies and interventions that are clearly having demonstrable results.

3.285 At the heart of each is a focus on retaining good employees, maintaining a productive workforce, and having workers give each other a fair go. They also, importantly, treat mental health as a mainstream issue which contributes to a broader de-stigmatisation agenda.

3.286 Dr Geoffrey Waghorn spoke about the potential for changing workplace culture:

> What's really exciting about this work is that, when you do succeed, everybody is amazed. The employer is amazed; the clinical team and psychiatrists are amazed; and their client and family are amazed. It brings home our Australian values really

275 Dr Jennifer Bowers, Australasian Centre for Rural and Remote Mental Health, *Committee Hansard,* 24 November 2011, Canberra, p. 3.

276 Dr Jennifer Bowers, Australasian Centre for Rural and Remote Mental Health, *Committee Hansard,* 24 November 2011, Canberra, p. 2.

> strongly when we can achieve this, because it changes the culture of the workplace. The workplace then learns that helping workers with mental illness is no different to helping all the other workers. It is just how much you get flexible and tailor the work circumstances to the person. So they really learn nothing except that good HR practices work for everybody.[277]

3.287 The Committee notes the variety of service providers that deliver generic, and, in some cases, tailored programs in this space for a wide range of organisations (from Beyondblue and Sane Australia to mental health first aid schemes and Comcare). Currently, the programs appear to operate fairly independently from each other. There may be scope for greater collaboration and coordination of the work each are doing in this space.

3.288 Further, Comcare, Defence, Abigroup and RioTinto have all indicated their willingness to share aspects of their own experiences and successes, best practice and lessons learnt.

3.289 This sharing of experiences is already happening. For instance, Abigroup has worked with the Committee for Economic Development of Australia (CEDA) to develop a discussion forum around the issue of addressing mental health in the workplace. Beyondblue also participated at that event, which was available to CEDA member organisations.[278]

3.290 Some government departments and agencies are doing more than others in this area. A number bring in an external provider like Beyondblue for employee training through the National Workplace Program. Few go to the lengths that Defence has. Yet, many witnesses emphasised that the Commonwealth public service as a major employer should take more of a leadership role in this area.

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277 Dr Geoffrey Waghorn RM, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, *Committee Hansard*, 9 August 2011, p.11.

278 CEDA website, http://ceda.com.au/events/eventdetails/2011/06/v110601?EventCode=V110601 viewed 16 March 2012.

Recommendation 9

The Committee recommends that the Commonwealth Government take a lead role in implementing best practice as an employer that looks after the mental health and wellbeing of employees, including the employment and retention of people with a mental illness.

3.291 Referencing the good work that Commonwealth departments and agencies are doing to support good mental health might form a core component part of the national anti stigma campaign recommended in Chapter one.

3.292 The national stigma reduction campaign should also draw on the experience of large employers doing good work in this space (such as those outlined in this chapter), and small to medium sized enterprises too.

4

Government and other service providers

We have moved away from thinking about tackling mental health as a health problem to thinking of it as a whole-of-government problem.[1]

...a cross-government, cross-sectoral approach is now well-recognised to much better support people with a mental illness to achieve a whole variety of goals and to participate more fully in the community.[2]

...consumers who are working use services less because they keep themselves well. They are motivated and they are busy.[3]

We have gone through changes and changes. We are a tired industry. We want to go back and focus on the people we are supposed to be working with and I think that is really getting lost and I think that makes all the difference in our outcomes.[4]

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1 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, *Committee Hansard*, 9 August 2011, p. 1.

2 Ms Bronwyn Hendry, Director, Mental Health Services, Department of Health, NT Government, *Committee Hansard*, 17 October 2011, p. 24.

3 Mr Todd Bamford, Team Leader, Transitional Care and Early Psychosis, and Noarlunga Emergency Mental Health Services, Southern Mental Health, Adelaide Health Service, South Australia, *Committee Hansard*, 7 June 2011, p. 22.

4 Mrs Melissa Williams, Manager, Gold Coast Employment Services, *Committee Hansard*, 8 August 2011, p.13.

Setting the scene: Commonwealth, state and territory responsibilities

4.1 In Australia, states and territories are responsible for the service delivery of health and education. This chapter will focus primarily on what the Commonwealth Government can do to encourage education, training and workforce participation of people with mental ill-health because the Committee can only effectively make recommendations to the federal government. States and territories have their own approaches and programs through their respective departments of health and community services, education, employment and training.

4.2 Responsibility for the national mental health and welfare reforms, the building the future workforce agenda, and the budgetary allocations that go with these (outlined in chapter one) are shared across several Commonwealth departments and agencies. These issues are no longer simply confined to the health and employment portfolios.

4.3 When considering the key issues raised by stakeholders in respect of government and other service providers, it is useful to outline the main department and agency players at the federal level, to sketch out their portfolio and program interests, and the various reviews and reforms they are undertaking.

4.4 The chapter will also draw on examples of best practice from the states and territories that participated in the inquiry, and focus on how all government instrumentalities including those of the Commonwealth, together with contracted service providers, can help people with a mental illness participate more fully in the workforce.

4.5 The Committee places on the record its appreciation of the participation in the inquiry of government departments from the following states and territories: South Australia, Queensland, Tasmania and the Northern Territory. This evidence has helped to build a picture of service delivery across the country.

Commonwealth Government

DEEWR, FaHCSIA and DoHA

4.6 The three Commonwealth Government departments responsible for the policy areas directly relevant to the topic of mental health and workforce participation are:

- the Department of Education, Employment and Workforce Relations (DEEWR), responsible for national education and employment policy as well as income support policy for working age payments;
- the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), responsible for national policy on disability benefits and the implementation of a number of community based mental health initiatives and other targeted early intervention services; and
- the Department of Health and Ageing (DoHA), responsible for national policy and programs to improve mental health outcomes, including through targeted prevention, identification, early intervention and health care services.[5]

4.7 DEEWR is the lead agency for policy relating to disability and employment. However, the joint submission from the three departments refers to their contribution as part of a 'cross-portfolio package to drive fundamental system improvements'. Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR said that there is:

> a greater integration of services and joint management of these issues across government...A key feature [of the national plans and programs] is that they are crossing boundaries between health, education, family and workforce settings to address the critical issues that may impact on an individual's capacity to gain and maintain work. [6]

4.8 As mentioned in chapter one, the 2011-2012 budget contained a number of measures to increase the workforce participation of people with mental illnesses. A number of these are outlined in Section A of the joint submission. Key existing programs are also outlined at Appendix A of that document.[7]

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5 DEEWR, FaHCSIA and DoHA, *Submission 62,* p. 5.

6 Ms Buffington, DEEWR, *Committee Hansard*, 14 October 2011, pp. 1-2.

7 DEEWR, FaHCSIA and DoHA, *Submission 62,* p. 5 and pp. 10-41.

4.9 To summarise, recap, and provide a focus for this chapter, some of the relevant initiatives under 'national mental health reform' include:

- an increase in funding to headspace (Australia's National Youth Mental Health Foundation) to expand existing and establish new youth focused mental health services for young Australians aged 12-25 years, providing for 30 current, 10 developing and a further 50 headspace centres by 2014-2015;
- engaging states and territories to share the cost of an additional 12 Early Psychosis Prevention and Intervention Centres (EPPIC) – there are currently four- to offer a range of community care services to keep people at home and out of hospital -to assist some 11, 000 young Australians with or at risk of developing a psychosis to access education and employment opportunities;
- expanding community mental health services, including through the provision of 425 new personal helpers and mentors. The Personal Helpers and Mentors Scheme (PHaMS) gives practical one-on-one support to people with a severe mental illness for everyday living and setting and achieving educational and employment outcomes. As part of this expansion, up to 1200 people with mental illness on DSP will have access to PHaMs services; and
- funds towards building the capacity of employment service providers and Department of Human Services (DHS) staff (i.e. Centrelink) to assist people with mental illness to gain employment and better connect them to the appropriate services.[8]

4.10 In addition to these initiatives, the Government is encouraging workforce participation through:

- the introduction of participation requirements for DSP recipients under 35 who are identified as having some work capacity; amending the DSP to allow all recipients to work up to 30 hours a week continuously for 2 years and still remain eligible for a part-time pension;
- targeted Disability Employment Broker projects to link job seekers with a disability to employers; improving assessments for DSP claimants who are required to undergo a Job Capacity Assessment to ensure appropriate options for employment support and income are provided to them;
- 20 Job Services Australia demonstration pilots to serve up to 5000 highly disadvantaged job seekers – including coordinating complementary services and joint-case management;

8 DEEWR, FaHCSIA and DoHA, *Submission 62,* p. 5 and pp. 14-18.

- and an information campaign to promote the benefits of employing people who have experienced labour market disadvantage, such as those with mental illness and/or the very long-term unemployed.[9]

4.11 Under 'Building Australia's Future Workforce' there are programs to improve apprenticeship opportunities and to increase access to the language, literacy and numeracy program (LLNP).[10]

DHS (CRS Australia, Medicare and Centrelink)

4.12 The Department of Human Services (DHS) has carriage of service delivery policy and provides access to social, health and other payments and services. In 2011, the *Human Services Legislation Amendment Act 2011* integrated the services of CRS Australia, Medicare and Centrelink into the one department.[11] It is perhaps worth emphasising that DHS is responsible for service delivery, rather than the overarching policy framework for mental health and workforce participation, which is DEEWR's responsibility.

4.13 CRS Australia (formerly known as the Commonwealth Rehabilitation Service) offers disability employment and assessment services to people with a disability, injury or health condition, including people with a mental illness. In addition to disability management and employment services, CRS Australia delivers return-to -work programs and workplace rehabilitation and injury prevention services:[12]

> CRS is one of many disability management services providers...we provide services across Australia from 180 offices and also from a number of visiting services...We have a multidisciplinary workforce, including around 1,100 allied health professionals (e.g. rehabilitation counsellors, occupational therapists, social workers, psychologists, skilled at working with people with disabilities, including mental illness).[13]

4.14 Medicare describes its role as delivering health and payment programs to Australians. Those relevant to people with a mental illness include:

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9 DEEWR, FaHCSIA and DoHA, *Submission 62,* pp. 11-13.

10 DEEWR, FaHCSIA and DoHA, *Submission 62,* pp. 10-11.

11 DHS website, http://www.humanservices.gov.au/corporate/about-us/

12 CRS Australia website, http://www.crsaustralia.gov.au/list_of_our_services.htm

13 DHS, *Submission 43*, p. 4 and Ms Alison McCann, National Manager, CRS Australia, *Committee Hansard*, 4 November 2011, p. 18.

- the Mental Health Nurse Incentive Program which funds community based general practices, private psychiatric practices and other appropriate organisations to engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental health disorders; and
- administering payments for General Practitioner Mental Health Care items, which provide a structured framework for GPs to undertake early intervention, assessment and management of patients with mental disorders. It also provides referral pathways to clinical psychologists and allied mental health providers.[14]

4.15 Centrelink 'assists people to become self-sufficient and supports those in need.' The Centrelink program:

> delivers a range of payments and services for retirees, the unemployed, families, carers, parents, people with disabilities [including people with a mental illness], Indigenous Australians and people from diverse cultural and linguistic backgrounds, and provides services at times of major change.[15]

Service delivery mechanisms for job seekers with a mental illness – JSA and DES

4.16 In July 2009 new employment services were introduced to replace the previous national employment service called Job Network Services. Job Services Australia (JSA) is the Commonwealth Government's new national employment service:

> For job seekers, it provides personalised help to find and keep a job...For employers, JSA provides a free service to help find staff to meet their business needs.[16]

4.17 The Government (through DEEWR) contracts a mix of small, medium and large, for-profit and not-for-profit organisations to provide employment services in more than 2,000 locations across Australia.[17]

4.18 JSA providers work with job seekers to develop an Employment Pathway Plan, which maps out the training, work experience and additional assistance needed to help them people find sustainable employment.[18]

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14 DHS, *Submission 43,* p. 5.

15 Centrelink website, http://www.humanservices.gov.au/corporate/about-us/

16 DEEWR website, http://www.deewr.gov.au/Employment/JSA/Pages/default.aspx

17 DEEWR, JSA website, http://www.deewr.gov.au/employment/jsa/employmentservices/pages/serviceproviders.aspx

4.19 JSA providers are able to access an Employment Pathway Fund (EPF) to purchase assistance in line with the individual job seeker's needs including training courses, travel assistance, work equipment and specialist counselling services.[19]

4.20 JSA delivers employment services under four main service streams:

> The streams reflect the level of disadvantage faced by individual job seekers, with the least disadvantaged receiving services under Stream 1 and job seekers with severe disadvantage, including non-vocational barriers (like homelessness and drug and alcohol dependencies) serviced under Stream 4.[20]

4.21 Disability Employment Services (DES) was introduced in March 2010 and is a complementary specialist employment service for job seekers with a disability, injury or health condition. Ms Buffinton, Group Manager, Disability Employment Services Group, DEEWR elaborated on the services that DES offers:

> As part of the whole new Disability Employment Services there is a much broader package of support and information. One of the excellent services is the Job Access Service, which is first and foremost a telephone support service. In the last budget that was expanded to include people with mental illness backgrounds and psychologists who can recommend and give support in physical environments where people can get workplace modifications. An example with mental illness would be that, before somebody goes into an environment, mental health first aid courses are provided in the workplace so that people are open and welcoming to people with mental illness rather than it being something that is silent or that people feel awkward about and do not know how to cope with.[21]

4.22 Like JSA providers, DES providers are contracted by DEEWR to provide employment assistance, but specifically for people with a disability, including those with a mental illness. There are 1,900 DES providers across Australia.[22] The national network comprises public, community and private organisations.

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18 JSA website, http://jobsearch.gov.au/provider/pages/whichprovider.aspx

19 DEEWR, FaHCSIA and DoHA, *Submission 62*, pp. 28.

20 DEEWR, FaHCSIA and DoHA, *Submission 62*, p. 28.

21 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 13 October 2011, p. 2.

22 DEEWR website, http://www.deewr.gov.au/Employment/JSA/JobSeekerSupport/Pages/disability.aspx

4.23 DES consists of two components:

> **Disability Management Service (DMS)–** provides help to people with disability, injury or health condition who require the assistance of a disability employment service and are not expected to need long-term or regular support in the workplace; and
>
> **Employment Support Service (ESS)** – assists people with permanent disability who are likely to need regular long-term ongoing support in order to retain their job.[23]

4.24 Under DES all eligible job seekers are able to receive an individually tailored program of assistance from their DES provider to help them prepare for, find and keep a job. DES providers seek to overcome vocational and non-vocational barriers to employment for their clients and offer various education, training and skills development opportunities.[24] In addition to the Job Access Service described above, DES supports include the wage subsidy scheme and the supported wage system (these supports have already been outlined in some detail in chapter three).

New participation requirements for DSP recipients

4.25 As of 1 July 2012, new participation requirements will come into being for DSP recipients, under the age of 35 and classified as having some work capacity. DSP recipients who are assessed as able to work 8 or more hours a week will be required to attend regular participation interviews with Centrelink to get advice on the impact of employment on their benefit, and the programs and supports available to help them find and keep a job. DSP recipients may also volunteer to be referred to JSA or DES providers. DSP recipients classified as being able to work 15+ hours a week will be required to look for work and be connected to an employment services provider. [25]

4.26 The participation requirements for DSP recipients are determined according to someone's assessed work capacity, as below:

- 0-7 hours per week – job seekers are not required to look for work but can volunteer to connect with an employment services provider;
- 8-14 hours per week – job seekers are not required to look for work but can volunteer to connect with an employment

23 Australian Government, Australian JobSearch website, http://jobsearch.gov.au/provider/pages/whichprovider.aspx viewed 21 February 2012.

24 DEEWR, FaHCSIA and DoHA, *Submission 62*, pp. 25-26.

25 DEEWR et al, *Submission 62*, p.11.

services provider. To meet their participation requirements [these] job seekers with a partial capacity of 0-14 hours must attend a quarterly interview with Centrelink unless they are meeting requirements through paid work;

- 15-22 hours per week – job seekers will be required to look for work or undertake work of 15-22 hours per week and be connected to an employment services provider. They may be required to accept an offer of paid work, provided the work is suitable;
- 23-29 hours per week – job seekers will be required to look for work or undertake work of 23-29 hours per week and be connected with an employment services provider.[26]

Fear of losing DSP and health entitlements

4.27 The fear of losing access to the DSP and its associated benefits, including access to a pensioner card (which discounts the sometimes expensive medications for some mental illnesses) is a paramount concern that DSP recipients have about seeking and securing employment, beyond the now permissible 30 hours a week. Anglicare Tasmania summarised:

> A barrier to seeking paid employment is the risk people face of losing their DSP – and the fear of relapsing into an episode of mental illness without any income at all.
>
> It is a deterrent for people to do 20/30 or more hours employment as they lose their DSP, housing rental goes up to full market rental and there is not much extra money per week for their contribution.[27]

4.28 Mr Dale Campbell, Chief Executive Officer, Top End Association for Mental Health, TEAMHealth agreed:

> Many welfare recipients will find themselves in a situation where they are reluctant to accept more than a minimal amount of paid work for fear of losing benefits...In some cases they can be materially worse off through losing benefits such as free transport, rent assistance and the like, while at the same time incurring additional costs such as transport, work clothing and things of that nature.[28]

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26 DEEWR et al, *Submission 62*, p. 21. More information on participation requirements is available from the DHS website, http://www.humanservices.gov.au/corporate/publications-and-resources/budget/measures/disability-and-illness/ptf20a

27 Anglicare Tasmania, *Submission 69*, p. 9.

28 Mr Dale Campbell, CEO, Top End Association for Mental Health, TEAMHealth, *Committee Hansard*, 17 October 2011, p. 18.

4.29 The Welfare Rights Centre corroborated this sentiment:

> People with mental health issues...are insecure about engaging in the workforce due to the episodic nature of their condition. The DSP is a safe option, not least because it provides recipients with a Pensioner Concession Card that makes medications much more affordable.[29]

4.30 A DSP recipient described the predicament consumers face:

> I don't want to lose my Health Care Card when I earn too much money. Medication is very expensive.[30]

4.31 Mrs Melissa Williams, Manager, Gold Coast Employment Services also spoke to concerns families have for their loved ones about the prospect of unaffordable medication:

> Families are often very hesitant for their young person because they are on four or five medications and if they lose their DSP or their concession card they will jump from $5.50 a script to $35 a script and they may have six.[31]

4.32 Open Minds similarly observed that the fear of losing welfare entitlements and other health benefits are 'primary reasons why people on the DSP do not participate in training, education or employment.'[32]

4.33 The National Employment Services Association (NESA) referred to a DSP Pilot Project undertaken by NESA providers that confirmed people perceived changed arrangements to the DSP as a potential threat, and they felt daunted by the prospect of having to reapply for the DSP should they become unwell and unable to work again:

> The risk of not being eligible for DSP under changed arrangements was not generally high but seen as a major risk and deterrent to participation which was often fed by headlines about the Government getting tough on welfare.[33]

4.34 There certainly appears some confusion about the rules and requirements surrounding the DSP benefit, its associated health care card, the work hours permissible and participation requirements alike. On the allowable work hours issue, Ms Heywood from TEAMHealth stated:

29 Welfare Rights Centre, *Submission 10*, p. 7.

30 Name Witheld, *Submission 55*, p. 1.

31 Mrs Melissa Williams, Manager, Gold Coast Employment Service, *Committee Hansard,* 8 August 2011, p. 14.

32 Open Minds, *Submission 27*, p. 2

33 NESA, *Submission 41*, p.6.

> I think that is a key issue...it is about educating the community and people so they understand that process.[34]

4.35 NESA underscored how important it is to reassure recipients that a safety net exists should a job not work out and they will not be worse off for venturing into employment.[35]

4.36 Orygen Youth Health proposed increasing the safety net effect saying:

> Consideration should be given to easing return to the DSP over a period of time after employment is commenced...We suggest that consideration is given to preserving some of the benefits of the DSP such as concessions on transport and utility bills for a period after employment commences to ease the transition to employment.[36]

4.37 In fact, DSP recipients do not automatically lose their benefit and health care card once they get a job: rather, it is a sliding scale. Essentially, work can be trialled and someone's DSP status maintained for a period of two years. Ms Melissa Lond, National Manager, Mental Health, Disability and Carers, from DHS explained:

> We need to help people understand that they can test their workability and that there are a lot of mechanisms to support them to do that, but there are also safety nets if it does not turn out to be sustainable employment. There has been a provision in the DSP legislation, since the payment was introduced, for suspension rather than a cancellation of the pension if a person attempts to return to work. If for whatever reason, they are not able to maintain that employment within a two year period they can have their pension restored without needing to go through the full assessment procedure again.[37]

4.38 The Centrelink website alludes to the sliding scale:

> The number of hours you can work and still receive DSP varies according to when you were granted the pension. If you work more than your allowable hours per week the DSP will not immediately be cancelled, it will be suspended for two years. This means if you find your job too difficult because of your disability

34 Ms Melissa Heyward, Director, Client Services, Top End Association for Mental Health TEAM Health, *Committee Hansard*, 17 October 2011, p. 21.

35 NESA, *Submission 41*, p.6.

36 Orygen Youth Health Research Centre, *Submission 28*, p. 5.

37 Ms Melissa Lond, National Manager, Mental Health, Disability and Carers, DHS, *Committee Hansard,* 14 October 2011, p. 11.

> or you need to reduce your hours of work in those two years, you can access DSP again without the need to prove your eligibility. Access to your Pensioner Concession Card continues for 12 months from the date your DSP is suspended.[38]

4.39 The joint department submission stated that all DSP recipients will soon be allowed to work up to 30 hours per week (as of 1 July 2012) – up from the 15 hours a week that was previously allowed:

> DSP recipients granted on or after 11 May 2005 will be able to work up to 30 hours a week continuously for two years and remain eligible for part pension. This will allow recipients to maximise their working hours without the suspension of their DSP entitlement. DSP recipients will still be subject to the application of the income test. The purpose of this measure is to remove a disincentive for DSP recipients to participate in the workforce and address the inconsistent treatment of people granted DSP before or after May 2005. **Note: people granted DSP before 11 May 2005 are already allowed to work up to 30 hours a week and remain eligible for a part pension**.[39]

4.40 On the health care card issue, Ms Lawson of the Welfare Rights Centre said that people need to know that there is a low-income health care card available [as an alternative to the pension card, should clients not be eligible for that].[40] Ms Lawson suggested ways to disseminate that message:

> Centrelink could advertise it more or provide information to people who are leaving the DSP after a review or after a year in employment when their pension card runs out. That information could be sent to them to let them know about it. We also think there is a greater issue of education and training for the community sector and the public mental health sectors.[41]

4.41 The Committee agrees that a communications strategy that effectively conveys these messages to all stakeholders is important, and will examine this further on in the chapter.

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38 Centrelink website,

39 Joint department submission, *Submission 62*, p. 12.

40 Ms Georgina Lawson, Project and Research Officer, Welfare Rights Centre Inc, *Committee Hansard,* 9 August 2011, p. 26.

41 Ms Georgina Lawson, Project and Research Officer, Welfare Rights Centre Inc, *Committee Hansard,* 9 August 2011, p. 28.

4.42 The Committee notes an apparent widespread misunderstanding about or lack of knowledge by DSP recipients of the mechanisms available to help people to transition off the DSP into employment.

Complex unwieldy bureaucracy

4.43 Consumers, consumer advocacy groups and employment service providers repeatedly referred to the difficulties that consumers face navigating their way through a complex social welfare system. Consumers spoke of having to 'explain their story' time and time again to bureaucrats and suggested that employment and social services should be better integrated, with any changes to consumers' benefit or pension entitlements more effectively communicated to them.[42]

4.44 Ms Gail Middleton, Executive Director of Welfare Rights Centre described the Centrelink system as 'extremely complex':

> The eligibility criteria are just becoming quite unbearable. I have worked in this industry now for 25 years and we have gone from a chart telling us what a person is entitled to, to booklets.[43]

4.45 Ms Georgina Lawson, Project and Research Officer, Welfare Rights observed that changes to the pension rules, including the new participation requirements, are but one example of change that can confound consumers and service providers alike:

> If we look at those new rules, you now have new and old rules for people in terms of their participation requirements. You have got different requirements depending on the person's date of birth and, come 1 January, you are going to have new and old rules in relation to an impairment table that is used for your reviews. There is a lot more to it than that, so the general community, the general recipient and many Centrelink officers do not know, and cannot be expected to know, all that information that is governed within those five common pieces of legislation that they use to determine someone's eligibility and entitlements, plus all the other policies that are used. We have created a monster in terms of the social security system and we have not matched that with any

42 See for example Name withheld, *Submission 65,* pp. 3-7, Welfare Rights Centre (Qld), *Submission 10*, p. 8, and Dr Geoff Waghorn, *Submission 15,* p. 4 and *Submission 15.1*, p. 6.

43 Ms Gail Middleton, Executive Director, Welfare Rights Centre Inc, *Committee Hansard*, 9 August 2011, p. 25.

> safeguards or quality information which is targeted towards the recipients and those who actually work with our recipients.[44]

4.46 Ms Emma Cotterill, Acting Director, Social Support, Commonwealth Ombudsman, referred to a system that is experiencing a high level of flux, and the subsequent scope for causing confusion:

> ...with there being so many changes on the table [with DSP] possibly means that things like the threshold for the number of hours that you can work without losing your entitlement possibly gets lost in the mix. The fact that the impairment tables are sort of up for review, the fact that there are other issues around people who are under 35 now potentially being asked to engage in participation where they previously have not been when they only have an eight hour capacity, I think it all mixes together and creates a lot of uncertainty about, 'Well, yes I understand the 30-hour rule but what if I lose it under the impairment tables?' There are too many things to juggle potentially that mean people will get confused and might understand one message but not the others.[45]

4.47 Mr Adam Stankevicius, Senior Assistant Ombudsman, Commonwealth Ombudsman spoke to the complaints his office receives. These highlight the fact that benefit recipients are not always clear about their obligations, nor are the explanations proffered by Centrelink always helpful:

> I think there is a whole series of tapers and thresholds in the social security system which confuses a lot of people. It happens in the youth allowance area as well as the DSP area and parenting areas where people are unsure about what threshold they meet and, if they go over the threshold...periodically, and they come back what impact does that have? We see a lot of complaints...they come to us because they have tried to go to Centrelink to get an explanation as to how it arose. The explanation is incredibly complex....and the response back from Centrelink has not made much sense.[46]

4.48 The Ombudsman also referred to Centrelink's correspondence as being problematic:

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44 Ms Georgina Lawson, Project and Research Officer, Welfare Rights Centre Inc, *Committee Hansard*, 9 August 2011, p. 29.

45 Ms Emma Cotterill, Acting Director, Social Support, Commonwealth Ombudsman, *Committee Hansard*, 14 October 2011, p. 32.

46 Mr Adam Stankevicious, Senior Assistant Ombudsman, Commonwealth Ombudsman, *Committee Hansard*, 14 October 2011, p. 31.

> They are usually quite good if they are about a single issue but once they are going to two or three issues they become a mish-mash because they are all automatically generated rather than individually generated.[47]

4.49 Mrs Hildred Kivelitz, Mental Health Coordinator, Carers, NT, described bureaucratic hurdles and the ensuing anxiety and stress that her clients experience when attempting to navigate the systems of Centrelink, service providers and other agencies. She relayed one man's story:

> Every time he received a letter from Centrelink his anxiety increased to a level of nausea and feeling physically paralysed. [48]

4.50 Ms Cherie Jolly, delegate of member organisation, Uniting Care Wesley Port Adelaide, Disability Employment Australia pointed to the toll that various assessment processes can place on people with a mental illness, especially when they need to be re-referred and reclassified:

> ...inaccuracy of referrals...puts people back through a system. They end up going back to Centrelink in stream 3 or 4, come back to us and fall out the system very disillusioned.[49]

4.51 Mrs Melissa Williams, Manager, Gold Coast Employment Services raised the issues of an increasing administrative burden on her staff of ever new guidelines, the difficulties of trying to always connect with the right person at Centrelink, and systems compatibility:

> Do you know where my training dollar goes now? On red tape – how to use this computer system, how we do that. It is not going on : how do we support this person with this diagnosis? It has just grown and grown. I am losing staff. I have just had a resignation today from somebody that basically just got to to the starting point, and they have just said, 'I love the job but I do not want all that.' So it is starting to impact.[50]

> You spend half your life looking up guidelines and cross-referencing. I guess it is an administrative burden on Centrelink and the department but trying to even find the right person you

47 Mr Adam Stankevicious, Senior Assistant Ombudsman, Commonwealth Ombudsman, *Committee Hansard*, 14 October 2011, p. 32.

48 Ms Hildrud Kivelitz, Mental Health Coordinator, Carers NT, *Committee Hansard,* 17 October 2011, p. 11.

49 Ms Cherie Jolly, delegate of member organisation, Uniting Care Wesley Port Adelaide, Disability Employment Australia, *Committee Hansard*, 13 October 2011, p. 8.

50 Mrs Melissa Williams, Manager, Gold Coast Employment Service, *Committee Hansard*, 8 August 2011, p. 12.

> are supposed to access is a nightmare due to the protocols on who to ring for help. It all takes my workers away. Because we cannot link the online diary that we have to use with our Outlook diaries, they are running two diaries all the time.[51]

4.52 Ms Buffinton from DEEWR acknowledged the issues regarding systems incompatibility, but countered:

> Over time, out IT systems will work better so we can flag if somebody has a concern. Service delivery will perform more broadly a wrap-around service. In the past we have had very different systems, but as we get better, if there is either somebody from the government or one of the employment services who has a concern, we will be able to flag concerns.[52]

4.53 As the next few sections will attest, the Committee can certainly appreciate how difficult it is for an outsider to get a handle on how all the elements of the employment and social services systems work and fit together. This could be even more difficult for someone with a vulnerability, including suffering from a mental illness.

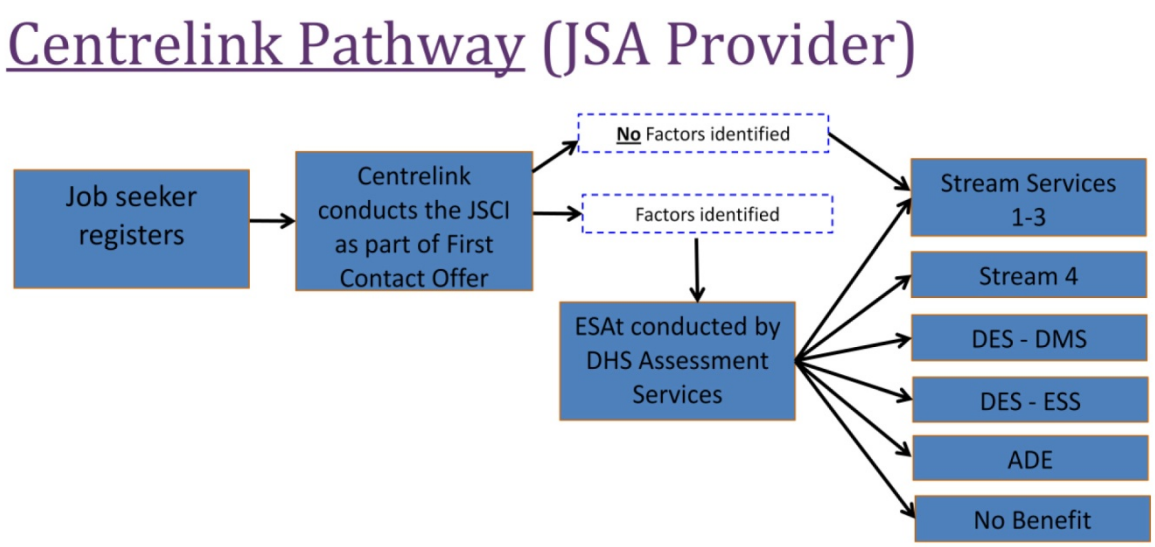
51 Mrs Melissa Williams, Manager, Gold Coast Employment Service, *Committee Hansard*, 8 August 2011, p. 14.

52 Ms Fiona Buffinton, Group Manager, Specialist Employment Services, DEEWR, *Committee Hansard*, 14 October 2011, p. 4.

Assessment and referral pathways

4.54 Figure 4.0 below shows how a job seeker is processed: assessed and referred on to generalist (streams 1 through 4 of JSA) or specialist employment services (DES).

Figure 4.0 Centrelink pathway (JSA Provider)



Source *DEEWR presentation on job seeker registration and assessment*

NB *ADE = Australian Disability Enterprises*

No benefit = someone who is assessed as having 0-7 hours work capacity and therefore not required to look for work.

4.55 The first assessment tool that someone encounters when registering as a job seeker with Centrelink is the Job Seeker Classification Instrument.

Job Seeker Classification Instrument

4.56 DEEWR is responsible for the administration of the Job Seeker Classification Instrument (JSCI). DEEWR describes the JSCI as:

> an objective measure of a job seeker's relative labour market disadvantage based on his/her individual circumstances. These individual circumstances are assessed using a job seeker's answers to the JSCI questionnaire plus other information known to influence employment prospects.

> The JSCI is designed to identify job seekers who, because of their individual circumstances, are likely to become long-term job seekers.[53]

4.57 Centrelink describes the JSCI as the tool they use to determine what employment assistance a person is eligible for. The JSCI consists of:

> a series of questions aimed at identifying what barriers you face entering the workforce. The JSCI is not intended to provide an individual assessment of your needs.[54]

4.58 DEEWR says that the JSCI determines the stream of services a job seeker is eligible for and/or whether further assessment is required though the completion of an employment service assessment:

> The key components of the JSCI are the factors (including sub-factors), questions, score and identification of the possible need for Employment Services Assessment (ESAt).
>
> The JSCI process involves collecting information about the factors using questions and other information derived from existing administrative data on the job seeker, to calculate a score used to determine a job seeker's eligibility for Streams 1, 2 or 3.
>
> Through specific responses to JSCI questions, the JSCI process may also identify the need for further assessment through an ESAt. The job seeker's eligibility for Stream 4 or DES is determined by the outcome of the ESAt.
>
> Where the ESAt recommendation is for Stream 1 to 3, the outcome of the ESAt finalises the JSCI score and determines eligibility for the appropriate Stream.[55]

Employment Service Assessments and Job Capacity Assessments

4.59 If a client is considered to require further assessment (that is they are not automatically allocated to streams one through three) they undertake an Employment Services Assessment (ESA or ESat):

> An Employment Services Assessment is conducted for disadvantaged job seekers identified as requiring further assessment of the impact of barriers on their capacity to participate in work or employment services.

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53 DEEWR website, http://www.deewr.gov.au/Employment/JSCI/Pages/overview.aspx

54 Centrelink website, http://www.centrelink.gov.au/internet/internet.nsf/services/jsci.htm

55 DEER website, http://www.deewr.gov.au/Employment/JSCI/Pages/JSCI.aspx

There will be two types of ESAts from 1 July 2011. These are

- Medical condition ESAt – An assessment of the job seeker's circumstances to determine work capacity and the most appropriate employment service, where one or more medical conditions are identified. ESAts are similar to the previous Job Capacity Assessments (JCAs) for potentially highly disadvantaged job seekers with disability, injury or illness. In a Medical condition ESAt the assessor must rely on the available medical evidence; and
- Non-medical condition ESAt – An assessment of the job seeker's circumstances that determines the most appropriate employment service, where no medical condition is identified — for example, a young person at serious risk of homelessness. A non–medical condition ESAt is normally less complex than an ESAt for a job seeker with disability, injury or illness, and will be streamlined to meet the individual's needs.

Wherever feasible, an ESAt will be conducted through a face to face interview. Where a face to face assessment is impractical for the job seeker (for example, due to geographic isolation or extreme weather conditions) or the job seeker has a medical condition or barrier which restricts them from attending a face to face interview, a video or phone assessment will be arranged.[56]

Eligibility for Stream 4 and Disability Employment Services (DES) is determined through an ESAt (for job seekers) or a JCA (for customers making claims for the Disability Support Pension).[57]

4.60 It appears that someone applying to go on the DSP must undertake a Job Capacity Assessment (JCA), rather than an ESat. Yet, a different part of the DEEWR website says that the Job Capacity Assessment program ceased on 30 June 2011.[58]

4.61 The Centrelink website states that it, or an employment service provider, will refer you for a JCA if you are applying for, or are on already on the DSP.[59]

4.62 The FaHCSIA website confirms:

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56 DEEWR website, http://www.deewr.gov.au/Employment/Programs/Pages/ESAt.aspx

57 DEEWR website, Job Seeker Classification Instrument, http://www.deewr.gov.au/Employment/JSCI/Pages/JSCI.aspx

58 DEEWR website, http://www.deewr.gov.au/employment/programs/jca/Pages/default.aspx

59 Centrelink website, http://www.centrelink.gov.au/internet/internet.nsf/vLanguageFilestoreByCodes/mcjca2100_0907_en/$File/mcjca2100_0907en.pdf

> A JCA is a comprehensive assessment of an individual's level of functional impairment and work capacity, usually conducted to determine qualification for DSP. The assessment identifies a person's:
>
> ⇒ level of functional impairment resulting from any permanent medical conditions,
>
> ⇒ current and future work capacity (in hour bandwidths), and
>
> ⇒ barriers to finding and maintaining employment and any interventions/assistance that may be required to help improve their current work capacity.
>
> A JCA can result in referral of a person to employment or support services that meet their individual needs, including JSA providers and DES providers.
>
> As part of the assessment process, assessors have access to relevant available information about the person, including current and past medical/disability details, and prior participation and employment history. Assessors can also liaise with treating doctors and other relevant health professionals as required.
>
> The JCA report is used by Centrelink to inform decisions on income support and participation requirements if applicable. A copy of the JCA report (not including impairment information) is also made available to the person's employment services provider.
>
> Generally, a JCA will remain current and valid for 2 years unless there is a significant change to a person's circumstances that affects their level of functional impairment and work capacity.[60]

4.63 The DEEWR website indicates that employment service providers can refer Stream 4 or DES job seekers for an ESAt in the event of any significant changes to that job seeker's circumstances that affects their work capacity/and or employment assistance needs.[61]

4.64 Ms Buffinton from DEEWR clarified:

> **ESA are the general assessment for employment. Those with a more complex case or those potentially for disability pension requirements are still known as job capacity assessments. These are carried out by allied health professionals.**[62]

60 FaHCSIA website, http://www.fahcsia.gov.au/guides_acts/ssg/ssguide-1/ssguide-1.1/ssguide-1.1.j/ssguide-1.1.j.10.html

61 DEEWR website, http://www.deewr.gov.au/Employment/Programs/Pages/ESAt.aspx

62 DEEWR website, http://www.deewr.gov.au/Employment/Programs/Pages/ESAt.aspx

4.65 Ms Buffinton alluded to changes that have brought employment services assessment back into to her department, DEEWR:

> Prior to 1 July [2011] there was a range of 18 providers. About 60 per cent of them were carried out by Centrelink and CRS Australia with the remainder carried out by another 16 providers, one government and the remainder private.[63]

4.66 The DEEWR website says:

> All ESAts are [now] conducted by qualified health and allied health professionals, such as a Psychologists and Registered Nurses employed by a single Government Provider under the Department of Human Services portfolio.[64]

4.67 Ms Buffinton emphasised that both JCA and ESAts are intended to build up a comprehensive picture of the person and their personal situation:

> The JCA or an ESA is not there as a diagnostic tool. It is there to work with a diagnosis that has come through from a health professional like a psychiatrist. These are trained allied health professionals. It is to see what the diagnosis is, but they are also trained in a much more holistic engagement of the person. Firstly, they are not doing a point in time of how a person appears at that moment in time during the discussion. They are taking a whole range of information [into account].[65]

Referral to DES

4.68 Figure 4.1 below shows how, following a job capacity assessment, clients are referred to or back to Centrelink (depending on whether they enter the system at a DES provider or Centrelink office level– most will enter via Centrelink), and are then referred on to a DES provider.

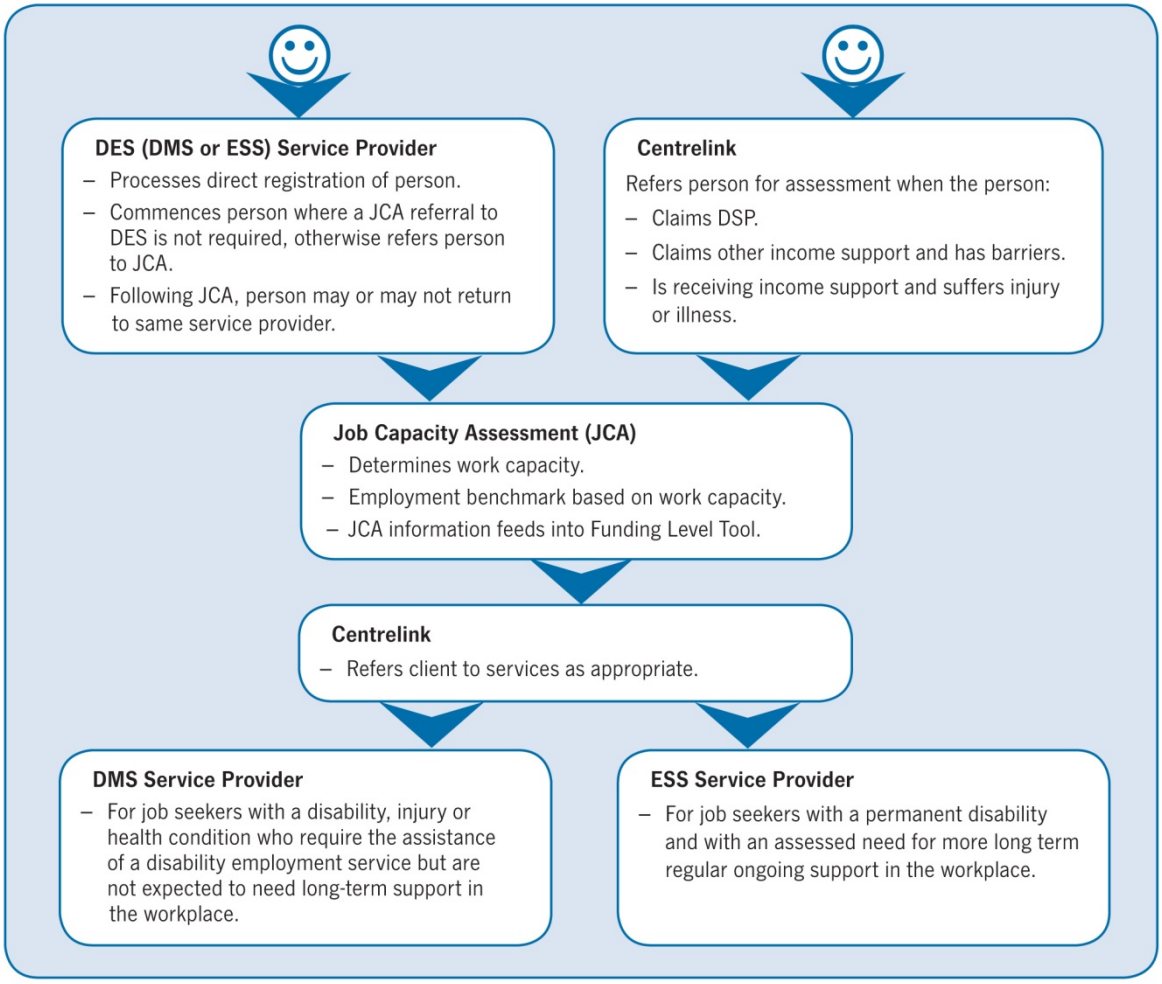
62 Ms Buffinton, DEEWR, *Committee Hansard*, 14 October 2011, p. 3.

63 Ms Buffinton, DEEWR, *Committee Hansard*, 14 October 2011, p. 3.

64 DEEWR website, http://www.deewr.gov.au/Employment/Programs/Pages/ESAt.aspx

65 Ms Buffinton, DEEWR, *Committee Hansard*, 14 October 2011, p. 3.

Figure 4.1 Pathways to DES



Source *Evaluation of Disability Employment Services Interim Report, Reissue March 2012*

Impairment Tables

4.69 There is another form of assessment that anyone applying for or on the DSP is subject to.

4.70 Eligibility for the DSP pension, in the first instance, is determined according to an impairment rating:

> As part of the qualification for DSP a person must have one or more physical, intellectual or psychiatric impairments that attract a total impairment rating of 20 points or more under the Impairment Tables.
>
> **Note:** A claimant who has a total impairment rating of at least 20 points, must also have a CITW (continuing inability to work) to qualify for DSP.
>
> Explanation: Some claimants may have an impairment rating of at least 20 points but do not have a CITW because they can work full-time where wages are at or below the minimum working wage or be re-skilled for such work within 2 years. [66]

4.71 The impairment rating has nothing to do with the referral process to employment services per se, but is mentioned here in the assessment section as another form of assessment a job seeker with a mental illness must undertake. Like other elements of the system, it too has been the subject of a recent review.

4.72 As a result, the tables have been modernised:

> Last year the Australian Government commissioned an expert Advisory Committee to review the tables and recommend revisions that are up to date with contemporary medical and rehabilitative practices...The report finds that the current Impairment Tables are out of date and contain anomalies and inconsistencies which have distorted the assessment process.
>
> The Advisory Committee has developed revised impairment tables...that, for the first time, include explicit guidelines about the impact of episodic or fluctuating conditions, such as some mental health conditions. This will help ensure assessments of eligibility for DSP for people with episodic conditions are fairer and more consistent than under the current tables.[67]

66 FaHCSIA website, Guide to Social Security Law, Version 1.186, released 30 April 2012, http://www.fahcsia.gov.au/guides_acts/ssg/ssguide-3/ssguide-3.6/ssguide-3.6.2/ssguide-3.6.2.100.html

67 DEEWR, FaHCSIA and DOHA, *Submission 62*, p. 22.

4.73 FaHCSIA says that the Tables now support a greater focus on functional ability and what people can do, rather than what they cannot do:

> For example, under the old Tables, ratings for some conditions such as back conditions were based on loss of movement. Under the revised Tables, ratings will be based on what the back condition prevents a person from doing.
>
> The old Impairment Tables contained anomalies and inconsistencies which distorted the assessment process.
>
> For example, under the old Tables when hearing impairment was assessed, a person with a hearing aid was not required to wear it, but someone who was having their sight impairment assessed had to wear their glasses. Under the revised Tables, people will be assessed when using or wearing any aids or equipment that they have and usually use.[68]

Problems with assessment and referral processes

4.74 In addition to the issues raised earlier, namely confusion about the new DSP participation rules, and Centrelink and the employment services' inherent complexities, the following areas of assessment and referral procedures were identified as further inhibiting participation of users of services: delays in processing; inappropriate assessments; and the re-referral process.

Delays in processing

4.75 Orygen Youth Health referred to lengthy assessment processes, as 'the de-motivation period' for clients who present to employment agencies wanting a job. Orygen said that assessment processes must be truncated in order to better engage the job seeker:

> Clients have expressed frustration at the long period of assessment they must undergo before initiating job-seeking. This assessment period can be up to two months in which time no job searching is done.[69]
>
> this period must be substantially reduced to provide optimum support and encouragement to young people with mental illnesses

68 FaHCSIA website, http://www.fahcsia.gov.au/sa/disability/payments/Pages/faq_impairment_tables.aspx

69 Orygen Youth Health, *Submission 28*, p.3.

> in their job seeking...everything possible must be done to make the job searching process easy to access and quick to produce results.[70]

4.76 The *Evaluation of DES Interim Report- Reissue March 2012* acknowledges that assessment delays are an issue:

> Streamlined access is another area for attention. The key indicator, the number of days from referral to commencement shows that on average job seekers are taking longer to commence service than under the previous programs.[71]

4.77 Ms Buffinton from DEEWR pointed to some of the reasons for delays, including people not presenting with all the necessary information or documentation in order to progress their assessment process.[72]

4.78 She also suggested that specialist disability employment services, by their nature, are more time intensive:

> The whole notion of DES is that it might not be that the instant you arrive you immediately get a job placement: it is a matter of what the employment service can do to value add. They will look at the barriers-if you have homelessness issues, if you have anger management issues, if you have a whole range of issues – and how you deal with those things and support you to be job ready so that when you connect with the employer, you match up very well.[73]

4.79 Further, baseline work is often required, necessitating a stepping approach. She elaborated:

> When a person's assessment is made, because the disability employment services work on the basis that this could be up to two years support, we do not necessarily expect that when you come into the employment services in month one you are out getting employment.
>
> ...before you even start getting employment outcomes there is a lot of baseline work done with the person, particularly in the case of mental illness, so that when the assessment is given the assessment is the potential work capacity of this person with intervention.[74]

70 Orygen Youth Health, *Submission 28*, p.4.

71 DEEWR, Evaluation of DES Interim Report, Reissue March 2012, p. viii, http://www.deewr.gov.au/Employment/ResearchStatistics/ProgEval/Documents/DESEvaluationDESfinal.pdf

72 Ms Fiona Buffinton, DEEWR, *Committee Hansard*, Canberra, 14 October 2011, p. 3.

73 Ms Buffinton, Group Leader, Specialist Employment Services, DEEWR, *Committee Hansard*, 13 October 2011, p.2.

74 Ms Fiona Buffinton, DEEWR, *Committee Hansard*, Canberra, 14 October 2011, p. 4.

4.80 The Committee is of the view that the assessment process should be expedited as quickly as possible with a view to engaging the job seeker as soon as practicably possible in the job search and job placement process or connecting them to further education and training.

4.81 To streamline the various assessment processes, DEEWR, Centrelink and employment services providers (JSA and DES) should work together to ensure that the assessment criteria for and requirements of job seekers with a mental illness are compatible and consistent across the services.

Recommendation 10

The Committee recommends that the Commonwealth Government work with employment service providers to streamline assessment processes for job seekers with a mental illness and ensure that the assessment criteria for and requirements of job seekers with a mental illness are compatible and consistent across the services.

Inappropriate assessments

4.82 Witnesses were critical of the JSCI and JCA processes insofar as they correctly identify, categorise and refer people on to the services most appropriate for them. Edge Employment Services in Western Australia said that:

> Job Capacity Assessments are not appropriately identifying and referring individuals with mental health issues to available services.[75]

4.83 Mr Lucas Mackey, a senior case manager from Workskills, provided a recent example where a client had not disclosed his full story to Centrelink, and presented to Workskills as a stream 2 job seeker, early school leaver, when he actually had a number of other vulnerabilities that should have been factored into his assessment [placing him into a higher stream level]. Mr Mackey elaborated:

> We are reliant on someone in a face-to-face meeting with Centrelink in the future picking up on that and then choosing further to question it.
>
> I know it has been freer in the past in the sense that job service providers have had an opportunity to refer back to Centrelink or to go to a job capacity assessor to have an assessment done. I am aware of the fact that organisations in the past have possibly

75 Edge Employment Services, *Submission 66*, p. 3.

> misused the instrument...I suppose a frustration from our point of view as an operational process is that all the organisations are tarred with the same brush as the organisation that abused the power...[76]

4.84 The NSW Consumer Advisory Group said individuals who are mentally unwell are not always qualifying for DSP because of inaccurate assessments. And, owing to their illness, they are not able to adhere to the requirements of the benefit they are put on instead, such as the Newstart allowance. This results in them receiving participation failures and experiencing periods of no payment from Centrelink.

4.85 One example they gave involved a mental health consumer who had a long-term alcohol addiction, which caused severe organ damage. They say his condition should have qualified him for DSP but he remained on Newstart allowance. His impairments had impacted on his ability to attend appointments with his JSA provider, he had received a participation failure and could incur an eight week payment cut off period. The consumer said of his own situation:

> I don't see the point of the entire system. If I get breached for eight weeks, I can't afford to pay my rent and then I will become homeless. If I am made homeless, I am going to be less likely to get a job than I already am. Plus while you are a breached Job Services gives you no assistance to look for work![77]

4.86 Disability Employment Australia (also known as ACE) emphasised that consumers with mental illness, especially significant psychiatric or psychotic illness can be a complex client group, with co-morbidities including substance abuse and homelessness and putting people into the wrong stream [or not on the DSP or into DES] means that providers are not funded to provide these people with the full suite of services that they may require:

> Funding level assessments are conducted via an independent IT based tool which collects non-subjective data from the JSCI and JCA report. Since the implementation of this methodology, feedback from the providers has indicated that clients with mental illness are trending towards the lowest funding level available.
>
> From ACE's perspective it is critical to ensure that the tool is as representative of the support needs of participants as possible- as

76 Mr Lucas Mackey, Senior Case Manager, Workskills Inc, *Committee Hansard*, 4 November 2011, p, 3.

77 NSW Consumers Advisory Group, *Submission 42*, p. 13.

> the level of funding is directly related to the amount of support that a provider is able to provide to a participant while still maintaining a financially viable service that is able to meet the needs of all participants. [78]

4.87 Some witnesses argued that part of the problem with the assessment and categorisation processes lies with the JSCI largely being conducted by telephone, rather than in person. The National Employment Services Association stated:

> The initial implementation of the Job Seeker Classification Instrument (JSCI) with job seekers is conducted on first contact with Centrelink and most often is conducted by phone interview.
>
> The industry has long contended that development of sufficient rapport and trust to elicit disclosure is best achieved in a face-to-face situation.[79]

4.88 Ms Helen Hudson from Workskills expressed similar frustrations:

> We find that quite often job seekers will come to us for their initial appointments and have been placed into a fairly low stream – stream 1 in a number of cases, or stream 2 or stream 3 – because that initial interview has been conducted over the phone.[80]

4.89 Mr Peter Ball, Service Leader, Department of Human Services, Tasmania Office explained how and why Centrelink had moved to provide job classification processes over the phone, rather than always via a face-to-face situation. He said this was something phased in over the last 18 months, and Tasmania had been part of the national trial. DEEWR and DHS believe the new model provides better services because:

> We could have more people who are better skilled available to more people over the phone.[81]

4.90 Moreover,

> My understanding is that DEEWR are comfortable with the phone-in service, otherwise I am sure they would have had robust conversations with Centrelink. In fact our ongoing processes are to work very closely with DEEWR as to how all the processes are going and how effective they are...I do not have responsibility for

78 Disability Employment Australia, *Submission 48*, pp. 7-8.

79 NESA, *Submission 41*, p. 7.

80 Ms Helen Hudson, Senior Case Manager, Workskills Inc., *Committee Hansard*, 4 November 2011, p. 1.

81 Mr Peter Ball, Service Leader, DHS, *Committee Hansard*, 4 November 2011, p. 12.

> the national management- my understanding is that DEEWR has worked with us nationally in that regard and are confident that the outcomes we achieve through the phone service are comparable to those that were achieved through the face-to-face service.[82]

4.91 DEEWR corroborated:

> in 2010 no significant difference was found in the consistency of Centrelink administered JSCIs, irrespective of whether the JSCI was completed at a face to face or telephone interview. Job seekers were allocated to the same service Stream between 90 to 94 per cent of occasions.[83]

Re-referral process

4.92 Concerns were raised regarding the ability to refer someone for reassessment if it appears they have not been placed in the right stream of employment service in the first place, or their circumstances are better identified at a later stage, or change, subsequent to their initial assessment.

4.93 JSA customers may initially be put in a general Stream 1 or 2 category because their illness is undiagnosed or undisclosed or they are well at the time of their initial assessment, however, owing to the episodic nature of their mental illness may later require assistance more in line with a Stream 3 or 4 level of vulnerability or a DES provider.

4.94 Ms Cherie Jolly, Delegate of member organisation, Uniting Care Wesley Post Adelaide, Disability Employment Australia pointed to the need for flexibility in the system to reclassify people, if necessary (although that too can cause problems):

> The flexibility of the program, starting with the job capacity assessments and the job seeker classification instrument, has a real impact...when people with a mental illness enter the Centrelink system they are generally at a point where they are really unwell. When they come to us, they are only partially through the recovery stage. They come to us with some stuff going on and they have their current and future benchmark hours...but the assessment itself should only be there to set criteria: they meet the criteria to come to us. Currently it is more about their funding level and what stream they go in and what their participation requirement is. That process brings an enormous amount of stress

82 Mr Peter Ball, Service Leader, DHS, Tasmania Office, *Committee Hansard*, 4 November 2011, p. 12.

83 DEEWR, Exhibit 41, JSCI Reviews Info.

> and pressure to bear on the individual, which often makes it difficult for us to engage. So flexibility around going back and being able to recall and reassess is one point we would like to highlight. That then brings inaccuracy of referrals and puts people back through a system. They end up going back to Centrelink in stream 3 or stream 4, come back to us, and fall out the system very disillusioned.[84]

4.95 Workskills reiterated difficulties they had experienced getting reassessments for their clients:

> If someone comes in exhibiting fairly significant symptoms of mental health issues and they are in stream 1, we can no longer refer them directly for a reassessment with Centrelink, which we used to be able to do...It is up to the job seeker to go to Centrelink and explain that they have particular problems and issues and request a further assessment or appointment with a social worker and so on.[85]

4.96 DEEWR indicated that employment service providers can refer clients back for reassessment. Ms Buffinton stated:

> On the rare occasions where a provider thinks that things may have not been disclosed, there are ways and means for the employment service to alert.
>
> It is rare but in more extreme cases they can refer for another assessment.[86]

4.97 Mr Alastair Bissland, Social Worker, DHS, Tasmanian Office said that it was his understanding that the inability to re-refer for streamed services review was 'nowadays no longer the case.'[87]

4.98 Ms Denise Frederick, Divisional Manager, Victoria/Tasmania, CRS Australia, alluded to the fact that it can take time for people to reveal and or realise the extent of their mental health condition, but the system can and does accommodate that:

> As a number of witnesses have identified this morning, sometimes it takes a little bit of time in the process as job seekers might reveal

84 Ms Cherie Jolly, Delegate of member organisation Uniting Care Wesley Port Adelaid, Disability Employment Australia, *Committee Hansard*, 13 October 2011, p. 7.

85 Ms Helen Hudson, Senior Case Manager, Workskills, *Committee Hansard*, 4 November 2011, p.1.

86 Ms Buffinton, *Committee Hansard*, 14 October 2011, p.3.

87 Mr Alistair Bissland, *Committee Hansard*, 4 November 2011, p. 12.

> further information, and we would work with them to obtain the appropriate medical information that would assist in getting them into the correct service...Most of the time we are the right place if the referral comes through, but if we are not then we need to take that forward. We would have interaction with the assessors. We do have sessions where we can talk to the assessor so that they really understand the service that we provide, because we think that is really important.[88]

4.99 Mr Niko Milec, Social Worker, DHS observed that re-assessment is an automatic part of the reconnection process when customers have participation failures:

> In the discussions we have with customers, mental health is a relatively common feature for those customers who were having significant difficulties engaging with their job service providers and engaging with their participation requirements...The JSCI is essentially reviewed every single time we have contact with a customer in relation to the participation report. Checking whether a customer is appropriately streamed is a critical part of that assessment. Certainly for social work, when we undertake comprehensive compliance assessments, which are an assessment that is undertaken before a decision is made about a serious failure, that would be almost mandatory.[89]

4.100 Mr Alistair Blissland, Social Worker, DHS agreed that the referral process can be problematic in identifying mental health issues when:

> Often we get referrals which are secondary or co-morbid issues. Those can be accommodation, drug and alcohol or domestic violence issues. Mental health is an underlying or latent issue.[90]

4.101 However, he noted that Centrelink is regularly in contact with external providers, including the employment services providers and they will respond to requests for additional assistance from service providers, including the reassessment of clients:

> on several occasions they have contacted us directly and said, 'we have a customer we are concerned about. They are presenting in

88 Ms Denise Frederick, Divisional Manager, Victoria/Tasmania, CRS Australia, *Committee Hansard,* 4 November 2011, p. 20.

89 Mr Niko Milec, Social Worker, DHS, Tasmania Office, *Committee Hansard*, 4 November 2011, p. 14.

90 Mr Alistair Bissland, Social Worker, Department of Human Services, Tasmanian Office, *Committee Hansard*, 4 November 2011, p. 13.

> an unusual way. They are manifesting depression, anxiety...Would you organise an appointment for them and any referrals and support?' which of course we do. That happens on a regular basis. The vast majority of referrals we get would be walk-ins or direct. Again, it would not necessarily be mental health as a presenting issue, but it would be a latent issue.
>
> Invariably the job service provider would ring us if there were any concerns [about a client's streaming for job services]. We would organise an appointment and in the course of the appointment we would do a brief mental health assessment. That may mean updating the JSCI, and, from there, organising another job capacity assessment.[91]

4.102 Mr Bissland cited a recent successful example of Centrelink working together with Workskills to re-stream a client with a mental illness:

> I had contact with Workskills directly when they rang up about a young chap that they believed was significantly depressed. He did not have a diagnosis and he did not have a GP and they sent him through to us. We did a brief assessment with him and it was fairly evident that he had symptoms of depression...so we did a written referral to a GP...He attended the appointment and got a medical certificate and doctor's report. We organised an assessment and from there he was streamed to a more appropriate provider.[92]

4.103 Mr Peter Ball, Service Leader, DHS advised further that:

> We do have regular meetings with Job Search providers and with DEEWR. In the case cited by Workskills, it sounds as though there has been a deficiency of some sort—perhaps a breakdown in communication there. But we do have in place those processes.[93]

4.104 DHS emphasised that the Commonwealth Government has sought to redress the problems with reassessments:

> The government has brought those assessment services back into government, delivered by the DHS with previous CRS and Centrelink staff. These are made up of allied health professionals and they cover a wide range of areas. Where a person has

91 Mr Alistair Bissland, Social Worker, Department of Human Services, Tasmanian Office, *Committee Hansard*, 4 November 2011, p. 13.

92 Mr Alistair Bissland, Social Worker, Department of Human Services, Tasmanian Office, *Committee Hansard*, 4 November 2011, p. 15.

93 Mr Peter Ball, DHS, Tasmanian Office, *Committee Hansard*, 4 November 2011, p. 15.

> information and evidence that requires a new assessment and they are in stream services, then they will approach a Centrelink office with that information and an appointment can be made for a stream services review. The assessment is made up on a job seeker face-to-face, where possible, and in the majority of cases, except if there are major barriers to that happening.[94]

4.105 DEEWR concurred:

> ...one of the things is making sure that the employment services get feedback if they have raised a query. We must make sure it is fed back whether we think there is a need for reassessments.[95]

DES performance

4.106 Ms Buffinton from DEEWR referred to a 2008 review of the disability employment services, and the job capacity assessments, then the gateway into the program. Ms Buffinton said:

> We developed the new Disability Employment Services learning from what was not right with the old system...That was developed in consultation with consumer groups, so the consumer groups were very actively involved – as were obviously employment providers, but also employers in the broader community.[96]

Uncapping of places

4.107 Ms Buffington stated that the 'single biggest element' of reform to DES has been the uncapping of places. Whereas, in the previous system, there was a waiting list and people could wait a year or more to get access, now people can get access as required.[97]

4.108 Dr Geoffrey Waghorn of the Queensland Centre for Mental Health Research endorsed this aspect of DES reform:

> There have been many positive enhancements to the program...such as uncapping program places and the introduction

94 Ms Hargreaves, National Manager, DHS, *Committee Hansard*, 4 November 2011, p. 15.

95 Ms Buffinton, *Committee Hansard*, 14 October 2011, p. 4.

96 Ms Buffinton, Group Manager, Specialist Employment Services, DEEWR, *Committee Hansard,* 13 October 2011, pp. 1-2.

97 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 13 October 2011, p. 2.

> of an independent ongoing assessment of support needs once people are in employment.[98]

4.109 National Disability Services agreed that the uncapping of places was an important move:

> The uncapping of the DES program in March 2010 provides an important precedent for this reform that would open pathways to employment and enhance flexibility and choice for employers and job seekers.[99]

4.110 Mr Todd Bamford, Team Leader, Transitional Care and Early Psychosis and Noarlunga Emergency Mental Health Services, Southern Mental Health, Adelaide Health Service, South Australia Health concurred and emphasised that previously, capping had been a significant barrier:

> when we consulted on the evidence based model, there was still a lot of capping, and that was raised just about everywhere as a barrier to being able to provide an evidence based service.[100]

4.111 The Committee learnt that subsequent to uncapping places, some agencies, such as UnitingCare Wesley Port Adelaide, had used that opportunity to expand into business areas they had not ventured into before. For instance, being part of the integrated service delivery model developed with Southern Mental Health (see later in this chapter for details).

Matching clients with DES providers

4.112 Despite the moves to uncap places, the Committee heard that some specialist service providers actually have a shortage of clients on their books, which they are not happy about. Mr Nick Bolto, the CEO of Ostara, a DES that focuses wholly on mental health, described how his service wants to help more people but is prohibited from so doing because clients are simply not being referred to their service:

> Most of our [114] sites are only half full or less than half full. We have talked to DEEWR and Centrelink. We have even had ministerial representation around the fact that, while government

98 Dr Geoffrey Waghorn RM, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, *Committee Hansard*, 9 August 2011, p. 10.

99 National Disability Services, *Submission 35*, p. 6.

100 Mr Todd Bamford, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 28.

> has funded specialist mental health services, people cannot get through the door. This is largely a policy issue of how job capacity assesses a client , interviews a client and then makes a decision about where the client will go. There is what they call the chocolate wheel. If the person makes no choice about the chocolate wheel spins and they get sent to a generalist provider. They have to ask for a specialist to get a service that meets their needs.[101]

4.113 Mr Bolto went on to explain that if a client does not explicitly 'opt in' to a specialist provider such as theirs, for reasons including the stigma of being sent off to 'disability' employment services, they will end up being 'randomly allocated to another [general] labour market support provider.'[102] Mr Bolto asserted that the problem is that:

> People do not know how to exercise their choice or why that choice is important.[103]

4.114 Ms Sharon Stuart, Branch Manager, Disadvantaged Job Seekers Branch, Specialist Employment Services Group, DEEWR refuted this, stating that the vast majority of people in DES do choose their own provider, after being appraised of the options available to them, and less than 10 percent of clients are part of any 'spinning chocolate wheel' system. Ms Stuart expanded:

> In fact over 90 percent of our clients have exercised choice...in some cases providers will find clients through the linkages they create in their own community or the client themselves will see some sort of promotion and come into a provider...People who come through the Centrelink gateway are given the options of the providers in their local area and asked to make a choice. If somebody has a primary psychiatric disability and there is a mental health specialist in that area, that particular provider will certainly show up on that list and be flagged as someone who works with that disability type, but the client will be given the choice of all of the other providers in that area. There are some circumstances where a provider's name may not show up on that list; that is where they have been sent a lot of referrals recently. They may temporarily drop off the list so that other providers can get some flow through.[104]

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101 Mr Nick Bolto, CEO, Ostara, *Committee Hansard*, 13 April 2012, p. 32.

102 Mr Nick Bolto, CEO, Ostara, *Committee Hansard*, 13 April 2012, p. 32.

103 Mr Nick Bolto, CEO, Ostara, *Committee Hansard*, 13 April 2012, p. 33.

104 Ms Sharon Stuart, Branch Manager, Disadvantaged Job Seekers Branch, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 13 October 2011, p. 6.

4.115 The Committee is of the view that time should be taken to explain the benefits of a specialist employment services provider to the client when Centrelink is going through all the options of providers in their area, and clients should be encouraged to make their own informed choice about the employment service provider they wish to try. This should not be immutable either, should things not work out with the first one they try.

Criticisms of DES performance

4.116 While Dr Waghorn, and others, support the uncapping of services, he offered an otherwise scathing assessment of the new DES' performance and proposed, in its place, an evidence based approach that centres on one-to-one assistance provided by a skilled employment specialist (this concept will be explored more fully throughout the rest of the chapter). He asserted:

> At the moment in Australia we have an increasing availability of ineffective services. The availability of services in Australia is no longer a barrier, except in remote locations. Australia now has a multibillion dollar disability employment industry, consisting of disability employment services contracted to DEEWR...the effectiveness has recently crashed. According to DEEWR's own interim evaluation released in July this year, specifically table 3.3 on page 31, only 10.6 percent of clients with a primary psychiatric disability at funding level two – the client group most relevant to our research – achieved 13 weeks of employment or an education pathway outcome in the nine-month period of March to December 2010. How can anybody say, 'wow' about a program that achieves 10.6 percent?
>
> The basic message is that it is the most populated subgroup of people with disabilities and it is the worst performing in the system The performance is now below what I would call a net zero effect.
>
> This evidence suggests that declining DES performance now represents the greatest barrier to employment for Australian community residents with severe mental health and psychiatric disability.
>
> The reasons for this declining performance...is a failure of the majority of DES providers to adopt the evidence based practices shown over the last 20 years to be the most effective in international trials for people with severe mental illness.

> It is that one-to-one arrangement that is done by a highly motivated, skilled, knowledgeable employment specialist that is an important part of the solution but the current DES providers do not do that. They are still operating along the lines of a JSA type service where it is all about volume, herding people through, coaching them in the office, giving them a list of things to do and sending them out in the big wide world and hoping some will make it.
>
> ...very good employment specialists do great deals with employers, back it up with reliable support and everybody wins through that. It is not easy but it can be done.[105]

4.117 According to Dr Waghorn the current funding structure acts as a disincentive to DES to find jobs for their clients. He asserted:

> DEEWR actually pay more for clients not to get a job than to get a job – over $15, 000 over two years for funding a level 2 client...all the service has to do is collect some referrals off a public mental health team, say all the right things, say they will do the work and rake in the service fees every quarter for having those clients on the books. They do not need to get a single person a job, and a service that has driven up their client load, to say, 50 clients, will collect $760, 000 fees over two years for one worker.[106]

4.118 Ms Buffinton's assessment of DES performance was contrary to Dr Waghorn's, namely that 'DES is working really well'.[107]

4.119 DEEWR has conducted an interim evaluation of the DES program. Of it, Ms Buffinton said:

> If you read the fine print on the interim evaluation, it was almost like a post-implementation check, which was just making sure that we got the program up and running. The new DES services started on 1 March 2010. The evaluation was done at the end of last year. So, at that time, when some people quoted some of those figures, the outcomes were quite narrow – as you would expect in a new program.[108]

105 Dr Geoffrey Waghorn RM, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, *Committee Hansard*, 9 August 2011, pp. 9-10.

106 Dr Geoffrey Waghorn RM, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, *Committee Hansard*, 9 August 2011, pp. 9-10.

107 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 13 October 2011, p. 2.

108 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 13 October 2011, p. 1.

4.120 The DEEWR website indicates that a further evaluation of the program is to be completed in the next financial year, 2012-2013.[109]

4.121 The Committee notes with interest Dr Waghorn's evidence regarding the perverse incentives that may exist in the present system, and believes his input should be sought in future evaluations of the DES program.

Disability Employment Services Performance Framework

4.122 Ms Buffinton went on to outline the Department's Disability Employment Services Performance Framework (the framework) and star ratings system which, in her words, assesses 'whether employment services are doing what we are asking of them and doing the best thing for the participant':

> The performance model measures the relative performance of providers. The framework is designed to drive performance and continuous improvement in the quality of delivery of services. We judge providers on efficiency, effectiveness and quality...We do this so disability consumers can see who is relatively high-performing and who is relatively low-performing. Twice a year we publish what we call the star ratings.[110]

4.123 The Committee recognises that the star ratings of all the disability employment services providers are published and made available on the DEEWR website.[111] And, if an agency specialises in mental health that is indicated on the star ratings spreadsheet. The accompanying explanatory information about how the star ratings are calculated should appear alongside the ratings (not on a separate web page as it presently does). A simple translation of what the star ratings might mean for the consumer regarding their choice of a provider should also be supplied on the website and relayed to clients in phone or face-to-face encounters with Centrelink.

4.124 The Committee is of the view that employment service providers that specialise in serving clients with a mental illness should be recognised and factored into the star-ratings system.

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109 DEEWR website, http://www.deewr.gov.au/employment/researchstatistics/progeval/pages/edesir.aspx

110 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard,* 13 October 2011, p. 4.

111 DEEWR website, http://www.deewr.gov.au/Employment/Programs/DES/PerfFramework/Pages/DESStarRatings.aspx

Sustainable employment and education outcomes

4.125 Ms Buffinton outlined how payments from DEEWR to DES providers for services rendered to people with a mental illness are increasingly weighted towards those which procure sustainable employment outcomes:

> Previously a lot of activity was rewarded whereas now we have become more outcomes oriented in how we pay disability employment services. A certain amount of fees are paid. Those service fees are relatively high because intervention for people with disability involves a lot of prep work before you are going to get outcomes. In the past there was a big focus on that activity and preparation. Now there is a balance between activity and preparation, but the emphasis is now on the outcome of actually helping somebody. After all, the whole aim of disability employment services is to help somebody get a sustainable-meaning ongoing-job in open employment. We have tried to bias the framework in the direction of those sorts of outcomes.[112]

4.126 DEEWR supplied a table setting out a range of DES service fees. These include job placement fees, 13 and 26 week outcome fees, quarterly ongoing support fees, and Job in Jeopardy Services Fees. There are a range of other reimbursements too, including ones that recognise an educational commencement or attainment. Further to Dr Waghorn's comments about the financial incentives to keep clients on the books rather than find them a job, and to provide some indication of the comparative monetary value of the one- off payments versus the ongoing payments: DES agencies receive $4, 400 for a 26 week full outcome for a DMS or ESS Funding Level 1 client. This increases to $7700 for an Employment Support Service Funding Level 2 client. Agencies receive $1450 for a 26 week pathway outcome for a DMS or ESS Funding Level 1 client, compared with $2,560 for an ESS Level 2. Ongoing support payments for DMS participants are $440 per instance. For other clients deemed to require moderate ongoing support, the agencies receive $1320 paid quarterly. This rises to $3300 per quarter for clients with high ongoing support needs. All fees command a premium for serving clients in remote areas.[113]

112 Ms Fiona Buffinton, Group Manager, Specialist Employment Services, *Committee Hansard*, 14 October 2011, p. 4.

113 DEEWR, *Submission 75*, p. 2.

4.127 DEEWR officials indicated that the 13 week and 26 week outcomes inform the star rating that an employment service gets, together with a range of other factors:

> The number of outcomes you get for that measure in comparison to your caseload counts towards 25 % of your star rating.[114]
>
> With the star ratings, disability type is one example of something we take into account. Others include the service requirements of participants, their higher-end needs, the labour market conditions of their particular location and so forth. We put that into a statistical regression which is used to adjust those factors. In the case of psychiatric illness, it is traditionally harder to achieve outcomes. So in the regression it gets a positive upweighting.[115]
>
> We basically rank all the providers on a scale.[116]

4.128 Dr Waghorn does not agree with the star rating or regression modelling used by DEEWR. He says to improve the efficiency of DES services, they need to be replaced:

> ...with a focus on a single outcome variable as the key performance indicator used to select or renew successful tenders. This key outcome needs to be the most challenging outcome, namely the proportion of clients that attain 26 weeks or more of accumulated employment during a particular contract. To assess this fairly, both diagnostic category and attrition also need to be accurately recorded, and employment in affiliated businesses to the employment system need must be either excluded as a non-competitive job or discounted in value through not being an optimal employment outcome.[117]

4.129 Employment service providers too had concerns with the outcomes payments and/or star ratings system. Ms Helen Hudson from Workskills Inc. stated:

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114 Mr Graham Harman, Director, Disability Employment Service Performance Section, Disadvantaged Job Seekers Branch, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 13 October 2011, p. 4.

115 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, *Committee Hansard,* 13 April 2011, p. 4.

116 Mr Graham Harman, Director, Disability Employment Service Performance Section, Disadvantaged Job Seekers Branch, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 13 October 2011, p. 4.

117 Dr Waghorn, *Submission 15*, p. 4.

> The way that contract is organised, there is no financial incentive for us to assist people with mental health issues to go that extra distance. People are providing that assistance but to a large extent that is unrecognised because there is no outcome, if you like, at the end of it. It is not getting a job for somebody. But if you assist people to get some help with their mental health issues that can be a huge positive step for many people.[118]

4.130 Similarly, Ms Cherie Jolly of Uniting Care Wesley Port Adelaide stressed that agencies do not always get rewarded for the work they put into preparing people for work:

> We get someone a job for three hours a week; that should be credited, but the time it takes us to get our performance up around that person involves putting the recovery stuff in place – the psychosocial stuff. So for speciality services there should be a lengthening of that performance. Our star rating at Port Adelaide is hideous because we maintain our values around preparing the person for sustainable employment.[119]

4.131 Orygen Youth Health expressed concerns that the JSA system focuses unduly on outcome payments, and does not incentivise educational outcomes for clients:

> In the course of our work we have met a number of people who were only a short distance away from completing various qualifications before they became unwell. When they engaged with JSA agencies they did not receive encouragement to return to and complete these courses. Instead they were placed in jobs that required no qualifications and encouraged to remain there until at least the period that corresponds with outcome payments was achieved....
>
> We believe very strongly that there needs to be incentives to encourage agencies to take a long-term view for the individual – to aim towards vocational recovery rather than job placement.[120]

4.132 Ms Phyllis Quensier, Service Integration Coordinator, Gold Coast Health Service, Queensland Health reiterated a point raised by Professor Butterworth in the first chapter that low quality jobs are probably not beneficial for people and self-defeating because:

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118 Ms Helen Hudson, Workskills Inc, *Committee Hansard*, 4 November 2011, p. 2.

119 Ms Cherie Jolly, Delegate of member organisation Uniting Care Wesley Port Adelaide, Disability Employment Australia, *Committee Hansard*, 13 October 2011, p.7.

120 Orygen Youth Health Research Centre, *Submission 18*, p. 8.

> That makes them very devalued to be seen as not worthy of anything better. Their motivation goes down, their stress levels increase and they can relapse due to the fact they are in a job that they feel they should not be in.[121]

4.133 Ms Buffinton defended the results so far:

> I will give you an indication of the current outcome rates because people are using historical figures in presentations to you. In terms of job placement under the Disability Management Service - 38% of those currently in the DES actually have a job placement, 26 per cent have hit a 13 week outcome and 18 per cent have hit a 26 week outcome. These figures are only going to build because we have only been running for 18 months. Obviously, if you came into the program in the last 6 months, you cannot possibly have a 26-week outcome. When we come back, those figures will build. Some of them are comparing against the old system, which had been running for a number of years and so had outcomes built up over quite a period of time. That is the efficiency and effectiveness side of it.
>
> On the issue of quality, all disability employment services are required to have certification that they meet the disability service standards.[122]

4.134 DEEWR indicated support for the new framework had been forthcoming from a wide range of stakeholders, and furthermore, it had been independently evaluated:

> We developed a technical reference group which had people from the former disability employment services, peak bodies, consumer groups and so forth. We looked at a whole range of different ways that we could judge performance. We then commissioned Access Economics to do some independent analysis of whether the model we had come up with was robust.[123]

4.135 The Committee is reluctant to recommend another review of the DES, when one was only conducted a few years ago and the new performance framework is expected to redress the shortcomings of the previous one.

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121 Ms Phyllis Quensier, Service Integration Coordinator, Gold Coast Health Service, Queensland Health, *Committee Hansard* , 8 August 2011, p. 22.

122 Ms Fiona Buffinton, Group Manager, Specialist Employment Services, *Committee Hansard*, 13 October 2011, p. 5.

123 Ms Fiona Buffinton, Group Manager, Specialist Employment Services, *Committee Hansard*, 13 October 2011, p. 4.

The Committee also notes that the Senate Standing References Committee on Education and Workplace Relations conducted an inquiry into the administration and purchasing of Disability Employment Services – Employment Support Services (DES-ESS) in 2011, making a number of recommendations including that DEEWR consider alternative purchasing models to the current one of a competitive tender process. The Government did not support this. [124]

4.136 Given that DES-ESS will continue to be funded through tender, and the Committee notes the current requirement that DES agencies meet disability service standards, the Committee does consider it essential that part of that tendering process require prospective employment service providers to be have some expertise in working with people with mental illnesses. This might form part of the star rating framework.

Recommendation 11

The Committee recommends that any future Disability Employment Services tender process require prospective disability employment services providers to provide evidence of expertise in working with people with mental illnesses.

4.137 The framework certainly warrants close ongoing attention, monitoring and evaluation, with input from interested stakeholders, to maintain their support. Presently, the star ratings appear to be heavily weighted towards quantitative outcomes (i.e. getting someone a job). This should not necessarily be at the expense of longer term qualitative outcomes, be these educational goals or career aspirations. In Professor Killackey's words, this may 'perhaps be in their long-term best interests.'[125]

124 See the government response to the Committee report, http://www.deewr.gov.au/Employment/Programs/DES/Documents/DESSenateInquiryResponse.pdf 12 February 2012.

125 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne, *Committee Hansard*, 24 March 2011, p. 7.

Recommendation 12

The Committee recommends that the Disability Employment Services Performance Framework be monitored and evaluated on a regular and ongoing basis. DEEWR should continue to consult with a technical reference group of stakeholders to ensure the framework's and star ratings' ongoing relevance and efficacy in achieving qualitative as well as quantitative outcomes for people with mental illnesses.

Improving communication and engagement

Disclosure and diagnosis

4.138 People are not always comfortable declaring their mental illness to government agencies or employment service providers. Sometimes they have an undiagnosed mental health condition. Either of these scenarios is a potential communication barrier to that person receiving appropriate services.

4.139 The National Employment Services Association (NESA) referred to the frustrations felt by employment service providers who find it difficult to connect their clients with the service they require because:

> ...the current classification framework is grossly inadequate to respond appropriately to people with low insight of their mental ill-health as it relies on self report and/or proof of diagnosis and impact to influence service classification.[126]

4.140 Ms Helen Hudson, Senior Case Manager, Workskills Inc. described the reluctance some job seekers with a mental illness have disclosing any information (about their illness or circumstances) to Centrelink for fear it might adversely influence their benefit entitlements, and the difficulties this poses to agencies like theirs, trying to help them:

> There are some job seekers with particular types of mental health issues – paranoia and anxiety in particular- where they feel that there is no way they are going to tell anyone from the government anything about their circumstances...We also have a number of clients who would need assistance through the DES and may have been recommended for those services as part of their assessment

126 NESA, *Submission 41*, p. 8.

> but refused to go to those appointments because of the stigma attached with the word' disability'...A lot of people will not admit that they have mental health problems and perhaps do not have any idea that they have mental health issues...[or] people may find it is okay to admit to depression which may be more socially acceptable to admit...rather than say that they are on medication for psychosis and things like that.[127]

4.141 Ms Nicole Cox, National Disability Coordination Officer, Edge Employment Solutions talked about some of the communication challenges presenting in the Kimberley region:

> Diagnosis and referrals are not occurring. ..They actually have to have informed consent by guardians, and in Indigenous communities there are often a lot of guardians...So it is a feat just for the psychologist to identify who legally they can be talking to...
>
> I sat in on a job capacity assessment by someone who came up from Perth....They asked the young lady whether she was Indigenous and she said 'no' and they ticked 'no' in the box. I had to explain about it. I asked questions like 'What is your country What is your language group?' She was able to answer. They also asked her if she had a disability and she said 'no'. You could tell she had a disability. She was sitting in a wheelchair. I asked her 'can you walk?'and she said 'no'. I would hate to think what would have happened if it had been an individual with a mental illness having that assessment. It is just so uncommon for an individual to identify.
>
> So there are huge issues around the job capacity assessments and the Centrelink assessments , and they all need to be modified to be culturally appropriate. [128]

4.142 Workskills referred to their Hobart site and communication challenges concerning new migrants:

> Our Hobart site observed that refugees and humanitarian entrants circumstances are not easy to document well through existing systems, e.g. experience of torture and trauma is not an available choice in JSCI questions (though post traumatic stress disorder is);

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127 Ms Helen Hudson, Senior Case Manager, Workskills Inc, *Committee Hansard*, 4 November 2011, p. 2.

128 Ms Nicole Cox, National Disability Coordination Officer, Edge Employment, *Committee Hansard*, 18 October 2011, p. 26.

> job seekers in these groups often distrust (perceived) government agencies; we, and they, put a lot of trust in their interpreters.[129]

4.143 Multicultural Mental Health Australia and the Transcultural Mental Health Centre referred to additional difficulties faced by people with a mental illness from cultural and linguistically diverse backgrounds, and a corresponding need for CALD-specific support workers:

> When people from CALD backgrounds with mental illness want to seek employment, some of the issues that they encounter are naturally language difficulties, and a lack of recognition of overseas qualifications, which often leads to them getting jobs below their qualifications or skills base. Some groups might not have an understanding of the recruitment process in Australia, how to write CVS or where to look for employment...there is also the interview process, imagine your English is not the best and you are exposed to that situation [and that]...there is a chance they will not be selected for interview because of the stigma attached to mental illness in the community.[130]
>
> Employing CALD-specific support workers and migrant resource agencies to run those PHaMs programs would be really good...
>
> I understand Centrelink runs community consultations from time to time to find out the needs of CALD consumers for courses and for welfare. Centrelink needs to run a lot more with a lot of different ethnic communities.[131]

4.144 The Commonwealth Ombudsman's *Falling through the Cracks* report identified greater consideration of the customer's barrier to communication and engagement as one of the four key areas for improvement for Centrelink and DEEWR alike.[132] Earlier parts of this chapter allude to the scope for miscommunication and disengagement, not least owing to a series of systemic and policy changes, from the introduction of a whole new employment services structure to streamlining the JCA process; new participation requirements; revised impairment tables and a new performance framework for the DES - to

129 Workskills, *Submission 34*, p. 3.

130 Ms Georgia Zogalis, National Program Manager, Multicultural Mental Health Australia, *Committee Hansard*, 17 June 2011, p.9.

131 Ms Georgia Zogalis, National Program Manager, Multicultural Mental Health Australia, *Committee Hansard*, 17 June 2011, p.10.

132 Ms Emma Cotterill, Acting Director, Social Support, Commonwealth Ombudsman, *Committee Hansard,* 14 October 2011, p. 29.

name but a few. Keeping all stakeholders abreast of developments can, at best, be described as a comprehensive challenge.

4.145 DEEWR said that it is acting on the *Falling through the Cracks* report recommendations, namely to update existing service delivery guidelines and training materials, and it provided the Commonwealth Ombudsman with a status report on those measures on 1 July 2011. The department stated that:

> DEEWR has either implemented the relevant recommendations made by the Commonwealth Ombudsman's report, 'Falling through the Cracks' or processes are well-developed to implement the recommendations.[133]

4.146 DEEWR said measures to improve communication and engagement include:

> the online mental health training package incorporates guidance for staff on how to ensure customers are aware of the benefits of disclosing a mental illness, and feel comfortable doing so. This will include information on how to foster an environment where disclosure can take place...DEEWR will continue to consider this recommendation with the development or enhancement of communication materials and staff scripts.[134]
>
> The Direct Registration Guidelines have been updated to include advice on what providers should consider if they identify that a job seeker may have mental health issues. Some suggestions include, seeking the assistance of a more experienced case manager or a JobAccess Advisor, organising alternative contact arrangements, consulting with the job seeker's nominee to determine the most suitable communication and contact arrangement, recommending that the job seeker discuss their circumstances with a mental health services provider, or referring the job seekers to other relevant support services.[135]
>
> The JobAccess Service has recently been expanded to include professionals in the mental health area who will provide information and support relating to the employment of people with mental illness...and includes funding to encourage

133 DEEWR, *Submission 75*, p. 3.
134 DEEWR, *Submission 75*, p. 7.
135 DEEWR, *Submission 75*, p. 4.

> employment service providers to access the expertise of the JobAccess Service.[136]

4.147 Centrelink says it too is making changes to strengthen decision making and reference material, specialist services and support to staff, through the following means:

- developing standardised 'pop-up' text when mental illness is mentioned in reference files. This will remind staff that consideration should be given to the various impacts on the customer's ability to comply, including their capacity to attend appointments;
- A Health Professional Advisory Unit (HPAU) established in July 20120 comprising medical practitioners and registered nurses to provide expert advice to Job Capacity Advisors, DSP decision-makers and Authorised Review Officers seeking clarification of medical evidence and/or information about treatment and rehabilitation regimes;
- In 2010, a total of 2, 428 staff participated in mental health first aid and mental health awareness training; and
- Piloting communication methodologies for people with disability as part of the DSP Workforce Reengagement Strategy. Face-to-face, phone, seminar and combined methodologies will be tested over a three year period.[137]

4.148 Centrelink officers described the range of communication strategies that the agency employs for communicating with other agencies and clients alike:

- Disseminating information to various groups through interagency forums and other seminars about what is happening; and
- We have promotional products which explain [concerns about losing benefits and some of the things that go with that].[138]

4.149 Ms Desley Hargreaves, National Manager, Social Work Services, Department of Human Services pointed to the challenges of communicating sometimes complex messages in accessible ways; to clients, namely:

> in simple ways that do help people to understand what their eligibility and entitlements are, and, when circumstances may change for them, what their options are.[139]

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136 DEEWR, *Submission 75*, p. 6.

137 DHS, *Submission 43*, p. 7.

138 Ms Desley Hargreaves, National Manager, Social Work Services, Department of Human Services, *Committee Hansard*, 4 November 2011, p. 12.

4.150 Ms Buffinton of DEEWR referred to money in the budget dedicated to training frontline staff, Centrelink and employment services providers alike, on dealing with people with a mental illness:

> In response [to the Ombudsman's report] we are pulling together a package of training material for the employment services and Centrelink staff.[140]

Training Centrelink and employment agencies staff

4.151 Ms Melissa Golightly Deputy Secretary, Health And Older Australians, DHS, spoke to the actual training staff receive and the suite of supports available to them to help them to do their job well:

> [staff] have at their fingertips access to properly trained and well-qualified social workers...and allied health professionals –health workers, nurses and that sort of thing, as well as psychologists, occupational therapists and doctors....for the frontline staff the focus is to be aware but not to feel that they have to deal with the issue themselves, and nor are they qualified to. We have an immediate escalation route or access route to a fairly significantly trained professionally qualified workforce.
>
> It is not the role of frontline staff to diagnose. Their role is to utilise flexibility, to demonstrate empathy and to have strong communication skills where a person is having mental issues...and to know when to call in the health professionals.[141]
>
> We have a range of training products targeted at staff in different roles. ...the training for [frontline staff as opposed to health and allied health professionals who already have tertiary qualifications in relevant fields]is more about awareness of mental health issues and disability awareness more generally, being able to identify where a person is having difficulty engaging with either the social security system or the employment assistance system, so that the person is able to exercise any flexibility that they have in the system in recognition that this person is having difficulty communicating, which is quite different from identifying the existence of a mental health condition per se.

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139 Ms Desley Hargreaves, National Manager, Social Work Services, Department of Human Services, *Committee Hansard*, 4 November 2011, p. 12.

140 Ms Fiona Buffinton, Group Manager, *Specialist Employment Services Group*, DEEWR, Committee Hansard, 14 October 2011, p.3.

141 Ms Malisa Golightly, Deputy Secretary, Health and Older Australians, DHS, Committee Hansard, 14 October 2011, p. 15.

4.152 Recognising the stressful situations that can present to Centrelink call centre and frontline staff by the very nature of the job, DHS indicated that its in-house cadre of professionals is available to help their own staff deal with the level of stress that can be experienced 'every single day of their lives and multiple times in one day'. [142]

4.153 The Committee certainly appreciates that the system can be incredibly complicated for consumers, service providers and Centrelink staff alike to navigate. It is not easy for anyone to follow, let alone someone with any kind of vulnerability, be it a mental illness or other, and supports all endeavours to enhance communication strategies, to clients, to staff serving clients and between agencies to support clients getting the services they need.

4.154 The Committee acknowledges that DHS/Centrelink and DEEWR themselves recognise this and are seeking to make improvements.

4.155 That noted, it is not clear that the agencies themselves are able to keep apace of the intensive pace of reform in the area, nor that the right messages are always reaching their intended audience.

4.156 Orygen Youth Health suggested that the marketing of employment services for people with mental ill health as 'disability employment services' may actually miss the intended target audience when:

> Most of our clients do not identify as having a disability and are consequently unlikely to follow up an ad that asks, 'Do you have a disability and want to work' (the wording used in one disability employment service that was advertised in our waiting room.[143]

4.157 A clear, effective and timely communication strategy to consumers that relays what services are available to them, and the potential impact of any introduced or other changes, pertinent to the client, should be of utmost priority. A range of visual, written and verbal communications will likely be necessary, in different languages. These might include a range of easy-to-read flyers to hand out to people, with case-study examples of people on the DSP/with identified mental illnesses who have ventured and/or transitioned successfully into employment and the ramifications of such moves for their pension entitlements, if any. Any explanatory guides and commensurate training provided to Centrelink and employment service providers to assist their clients in these areas should similarly disseminate

142 Ms Malisa Golightly, Deputy Secretary, Health and Older Australians, DHS, Committee Hansard, 14 October 2011, p. 15.

143 Orygen Youth Health, *Submission 28,* p. 4.

information in a timely and user-friendly manner. The communications strategy should be cognisant of a diverse audience, inclusive of people from all backgrounds, offer a positive message of assistance on offer and encourage engagement with the services.

Recommendation 13

The Committee recommends that DEEWR and Centrelink prioritise the implementation of a clear, effective and timely communication strategy that advises clients of the services and supports available to them, including how changes like the participation requirements and revised impairment tables will affect them.

The Committee expects that any accompanying explanatory guides and commensurate training provided to Centrelink and employment service providers by DEEWR and DHS to assist clients with mental health conditions will similarly be provided in a timely manner and user-friendly format.

Consumer input into policy change

4.158 Ms Lawson from the Welfare Rights Centre pointed out how vital it is to incorporate consumer participation in developing and altering welfare policy:

> It is the 'nothing about us without us' kind of concept. There need to be people with mental health issues involved at all levels of policy development.[144]

4.159 Ms Hargreaves from DHS referred to the existence of a national disability reference group that includes representatives of peak bodies who advocate on behalf of disability constituents.[145]

4.160 The Committee thinks that it is equally important to consult Centrelink staff and employment service providers as they are the interface between the client and the system.

144 Ms Lawson, Welfare Rights Centre, *Committee Hansard*, 9 August 2011, p. 26.

145 Ms Desley Hargreaves, National Manager, Social Work Services, Department of Human Services, *Committee Hansard*, 4 November 2011, p. 12.

Recommendation 14

The Committee recommends that any new communication strategies be developed with input from clients and staff (from both Centrelink and employment service providers) into how best to disseminate information to clients so they can readily understand any changes to their entitlement and participation requirements.

4.161 The Committee heard anecdotal evidence that DEEWR staff responsible for disability employment policy do not regularly visit Centrelink sites. In addition to any inter-departmental contact that DEEWR and DHS have, the Committee also thinks it important that DEEWR officers working on policy that affects DHS, regularly visit Centrelink offices so that they may have a first-hand appreciation of the impact of DEEWR policy on service delivery practice for consumers and staff.

Community engagement officers

4.162 Dr Waghorn called for the reintroduction of disability liaison officers as one way to improve engagement between the consumer and Centrelink. Previously located within Centrelink offices, they had, he said, served pension recipients well. He himself had been a disability liaison officer and seen first- hand the benefits of being able to offer specialist one- on-one advise to clients, helping individuals work out what they were required to do and the ramifications of any changes for their benefit entitlements.[146]

4.163 Mrs Melissa Williams, Manager, Gold Coast Employment Support Service indicated that the disability liaison officer positions in Centrelink had served providers like her well too:

> Years ago we had disability liaison officers at Centrelink who were trained and who were a one-stop shop for any concerns. It was the saddest day when they were removed. Trying to get any assistance through Centrelink is time consuming even for me as an agency, let alone for people who have these significant barriers. It gets all too hard and stressful a lot of the time and, rather than linking our services and getting things more smoothly, it is a deterrent. So I would say bring back the disability officer.

146 Dr Geoffrey Waghorn RM, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, *Committee Hansard*, 9 August 2011, p. 16.

> Centrelink can be overwhelming and intimidating, especially for people that are not really well and even if you are really well.[147]

4.164 Ms Gail Middleton, Executive Director, Welfare Rights Centre did not disagree but said:

> The trouble is you cannot have a single approach. To bring back disability officers would be good, but it does not replace the fact that some people are fearful of Centrelink itself. Some people need other safeguards in place and there needs to be more information out there for the people who interrelate with recipients...[148]

4.165 Dr Geoffrey Waghorn also spoke to clients' fear of Centrelink itself:

> Even if you go through with a person and show them using a budget calculator that their rate of DSP is only going to go down by that much, but their earnings are going to go up by that much and are only going to pay that much tax and the net gain is going to be $35 a week from 10 hours a week employment...even if you show them that, they will come back and say, 'But I can't deal with the stress of having to deal with Centrelink."[149]

4.166 Ms Desley Hargreaves, National Manager, Social Work Services, DHS observed that the right messages may be being relayed to an individual but, 'it is not always being processed or understood' [when someone is ill].[150]

4.167 Mr Peter Ball, Service Leader, Department of Human Services outlined how the presence of 'community engagement officers' in Tasmania had made a difference there:

> We have community engagement officers who operate in the three rough geographic areas of Tasmania, the south, the north-east and north-west...they go into the neighbourhood houses and the like and they work directly with those people to make sure that they continue to be engaged.[151]

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147 Mrs Melissa Williams, Manager, Gold Coast Employment Services,*Committee Hansard*, 8 August 2011, p. 13.

148 Ms Gail Middleton, Executive Director, Welfare Rights Centre, *Committee Hansard*, 9 August 2011, p. 29.

149 Dr Geoffrey Waghorn RM, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, *Committee Hansard*, 9 August 2011, p. 16.

150 Ms Desley Hargreaves, National Manager, Social Work Services, DHS, *Committee Hansard*, 4 November 2011, p. 16.

151 Mr Peter Ball, Service Leader, DHS, *Committee Hansard*, 4 November 2011, p. 16.

4.168 The Community Engagement Officers program offers outreach assistance in a wide range of locations, including mental health units. Community Engagement Officers keep services connected to the client, and can assist clients in an environment where they can be supported by other people such as hospital staff.[152]

4.169 This program seems to be one way to break down barriers between the client and Centrelink, and increase the likelihood of the right connections being made.

PHaMS Remote Service Model

4.170 Another example of a complementary service model is the PHaMs Remote Servicing Model which aims to better service Indigenous Australians in remote areas:

> The PHaMs remote service model differs to the mainstream service, with a strong focus on spiritual, cultural, mental and physical healing for Indigenous Australians. The model incorporates more traditional cultural healing practices and utilises broader community activities to support healing. It aims to enable social inclusion and strengthening of family and community relationships for the participant, as well as the development of the community as a whole.
>
> As part of this new remote servicing model, FaHCSIA partnered with a young designer, photographer, the PHaMs team (Warra-Warra Kanyi) and the Warlpiri people of the Yuendumu community, to develop promotional products that better reflected the remote Indigenous communities PHaMs would now be operating in.
>
> A workshop was held in the community and over a week, the local community members designed the concept that would represent PHaMs and what mental illness means in an Indigenous context. The local landscape was photographed and incorporated into the background and border. The community was given final sign off of the cultural appropriateness of the products before they could be used.[153]

152 Centrelink website, http://www.humanservices.gov.au/customer/services/Centrelink/community-engagement-officers

153 FaHCSIA website, http://www.fahcsia.gov.au/sa/mentalhealth/progserv/PersonalHelpersMentorsProgram/Pages/default.aspx#4

4.171 The PHaMS program was outlined in some detail in Chapter two and endorsed by a number of witnesses as adding value to their educational and employment prospects.

4.172 The FaHCSIA website indicates that Round 4 funding (until 30 June 2012) includes over $36 million funding for additional PhaMS services (in 17 current and 10 new sites) focusing on particularly vulnerable people experiencing mental illness such as:

- those who are homeless or at risk of homelessness
- humanitarian entrants, and
- Indigenous Australians. [154]

4.173 The Committee believes it could be beneficial to raise the profile of programs that help job seekers with a mental illness link to job opportunities, such as Centrelink community engagement officers and PHaMs,, as part of the national education campaign that the Committee recommends in chapter one.

Encouraging inter-agency communication and case-coordination

4.174 Having effective communication channels between agencies and clients is one very important part of the equation for assisting people with a mental illness get the services they need to find and sustain employment. Another integral component is effective inter-agency communication and coordination.

Collaborative partnerships, integrated employment services and strength based approaches

4.175 One of the resounding messages of the inquiry is the importance of leveraging collaborative partnerships and ensuring that employment services are integrated with clinical and social services to make them easier to access and more effective for consumers.

4.176 Disability Employment Australia would like to see employment service specialists work together with the assessors:

154 FaHCSIA website, http://www.fahcsia.gov.au/sa/mentalhealth/progserv/PersonalHelpersMentorsProgram/Pages/default.aspx#4

> To increase the appropriateness and accuracy of these judgements, as we believe that decisions around that economic potential are best made in context and in partnership with the participant and provider – based on a strength based and person centred assessment approach.[155]

4.177 Ms Melissa Lond, National Manager, Mental Health, Disability and Carers, DHS said that Centrelink, as a service agency, needs to employ strength based strategies to help people understand that they can test their workability.[156]

4.178 Ms Malisa Golightly of DHS elaborated on a strength based perspective:

> It is focusing on what [clients'] strengths are rather than what the problems are. That is not to ignore the problems, but it is a way of getting people into a space where you are building confidence for a start, but you are able to talk about options. We have seen this work really well through place based activities that we are doing.[157]

4.179 DHS added that:

> Utilising a strength-based approach builds the trust and confidence of vulnerable people to access services and support in their community.[158]

4.180 The Queensland Government states:

> Providing strengths-based training within an individual's recovery plan would assist in building their ability to participate in education, training or employment.[159]

4.181 Other witnesses agreed. Headpsace:

> recommends that the government focus on enabling, strength-based policies, holistic support, and the creation of meaningful jobs for young people.[160]

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155 Disability Employment Australia, *Submission 48*, p. 7.

156 Ms Melissa Lond, National Manager, Mental Health, Disability and Carers, DHS, *Committee Hansard*, 14 October 2011, p. 11.

157 Ms Malisa Golightly, Deputy Secretary, Health and Older Australians, DHS, *Committee Hansard*, 14 October 2011 p. 11.

158 DHS, *Submission 43*, p. 8.

159 Queensland Government, *Submission 56*, p. 36.

160 Headpsace, *Submission 13*, p. 13.

4.182 The following initiatives or models are all examples of a strengths-building approach that integrates employment specialists and adopts a collaborative modus operandi:

- the Place Based Services Program (PBS), which was a precursor pilot for case-coordination;
- the Local Connections to Work Program (LCTWP);
- Local Employment Access Partnerships (LEAP);
- the co-location of CRS, VETE and Headspace;
- Early Psychosis Prevention and Intervention Centre (EPPIC) and Individual Placement and Support (ISP) exemplified by Orygen Youth Health;
- the Queensland Health model-complex needs panels;
- and the Southern Adelaide Health integrated services approach.

Place Based Services Program (PBS)

4.183 DHS referred to ways it has sought to better reconnect people with services, including through the Place Based Services Program trial:

> In 2008/2009 Centrelink initiated the Place Based Services (PBS) Program to trial more intensive support for disadvantaged and vulnerable customers in seven geographic locations, aimed at producing more productive and sustained connections between the customer and support services within their community.
>
> Each trial site developed local responses to problems specific to their local area, developing responses to strengthen service delivery arrangements and build the capability of these networks to better respond to the needs of disadvantaged and marginalised people. In each case, responses were built around local partnerships between Centrelink, state and local governments and local business and community partners and importantly, marginalised Australians. [161]

4.184 According to DHS, key lessons learnt from this trial are informing the development of service delivery reform. These important lessons include that:

161 DHS, Submission 43, p. 7.

- Centrelink is one of the key agencies uniquely placed to identify and connect people to appropriate services;
- Working with people with significant disadvantage requires the involvement of highly skilled staff, including social workers and experienced Centrelink customer service advisors, cross-disciplinary teams allows for the optimal use of resources;
- The collaborative component within each initiative demonstrated the potential to improve social inclusion through advocacy, identifying and filling service gaps, better service delivery, networking and information sharing;
- Experience shows that building a relationship with a person who feels marginalised requires time, and multiple interviews. Investing this time has downstream benefits. Similarly, investing time to ensure that the person makes an effective transition to appropriate services is a critical element of achieving improved and sustainable outcomes.[162]

Local Connections to Work

4.185 DHS outlined the ethos behind the Local Connections to Work Initiative (LCTW) - which built on the PBS model. In existence since May 2010, and based on the successful New Zealand 'Community Links' model, LCTW aims to bring together a range of services under one roof to assist long-term unemployed and disadvantaged job seekers better access services:

> THE LCTW initiative brings together Australian, state and local government services, employment service providers and other community welfare organisations. Services provided include counselling, housing, mental health, youth, training and financial assistance. Community partners are co-located on rostered basis at the four Centrelink Customer Service Centres. This means that disadvantaged job seekers can 'tell their story once' and receive the range of wrap around services.[163]

4.186 Ms Malisa Golightly, Deputy Secretary, Health and Older Australians, DHS, spoke to the successes of the initiative for job seekers with a mental illness:

> Local Connections is very much a team effort where you have Centrelink, the employment service provider, and the local support, which might mean the mental health advisory service and the employer, all working together with the employee on

162 DHS, Submission 43, p. 8.

163 DHS, *Submission 43*, p. 9.

> what the strengths are of the employee and what might be possible. That is where we can do great things.[164]

4.187 One of the strengths of the LCTW model is its emphasis on local solutions for local people and the utilisation of community partners:

> The actual services provided on-site through LCTW are driven by local needs and tailored to the specific circumstances of job seekers and their families.
>
> Employment Services Providers play a vital role in this collaboration and on-site services are provided by both Job Service Australia and Disability Employment Services providers.
>
> Community organisations can get involved with the LCTW program by contacting their local office. You can be involved on-site or be a member of the Community Partnerships Group, which works towards finding ways to better deliver services to the community.[165]

4.188 Mr Peter Ball, Service Leader, DHS outlined the benefits to consumers and clients alike of the LCTW process:

> In our Burnie office, on the north-west coast, in February this year we commenced a process that we call Local Connections to Work...where we are bringing other agencies into our offices so that we can work on a partnership basis with the other agencies and with the individual customer. So it may well be that there is a joint interview with a job services provider and a Centrelink person. But also then, maybe, if there is an issue to do with alcohol and drug dependency, we have a direct referral and maybe a three-way conversation with those people as well.[166]

4.189 The program emphasises 'case coordination'. Mr Ball elaborated:

> We are allowing our people a longer period of time to have more in-depth conversations with people who have major or more apparent barriers to interconnecting and staying connected, so that we can make some direct referrals...it seems to us that what works more directly is, rather than making a referral and saying to someone you need to go up the road, we either make the

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164 Ms Malisa Golightly, Deputy Secretary, Health and Older Australians, DHS, *Committee Hansard*, 14 October 2011, p. 15.

165 Centrelink website, http://www.centrelink.gov.au/internet/internet.nsf/individuals/lctw.htm

166 Mr Peter Ball, Service Leader, DHS, *Committee Hansard*, 4 November 2011, p. 16.

> appointment [for the client], or better still take the person round the corner and up the road to that particular agency.[167]

4.190 The National Employment Services Association (NESA) praised the LCTW pilots from a service provider's point of view:

> We note that provider participation in the LCTW pilots report that in contrast to normal arrangements the assessment interviews jointly conducted by themselves and Centrelink in a face-to –face interview were highly effective at identifying a range of circumstances, including mental ill- health. These interviews were comprehensive and effective and worth the investment of resources with interviews taking an hour and a half in duration.[168]

4.191 The Centrelink website includes a video clip of one young woman citing her experiences and the range of help that LCTW gave, from securing stable accommodation through to finding a job and regaining self-esteem and confidence.[169]

4.192 LCTW has built on its successes and from June 2012, the program will operate from 14 service centres.[170]

4.193 The Committee watches the roll-out of the LCTW program to more sites with great interest and thinks it has real potential to assist clients with mental illnesses both find and sustain a job at the same time as deal with a raft of other issues they may have from a drug dependency to homelessness to need for advice on benefit obligations.

Local Employment Access Partnerships (LEAP)

4.194 The Australian Government provided $41 million to Innovation Fund projects that ran from 2009-2012:

> The Innovation Fund is a component of the Australian Government's national employment services, Job Services Australia. It is designed to address the needs of the most disadvantaged job seekers through funding projects that will foster innovative solutions to overcome barriers to employment which they may face. Innovation Fund projects also contribute to

167 Mr Peter Ball, Service Leader, DHS, *Committee Hansard*, 4 November 2011, p. 16.

168 NESA, *Submission* 41, p. 9.

169 Centrelink website, http://www.centrelink.gov.au/internet/internet.nsf/individuals/lctw.htm

170 Centrelink website, http://www.centrelink.gov.au/internet/internet.nsf/individuals/lctw.htm

> the achievement of the Australian Government's Social Inclusion Agenda by supporting innovative strategies to help the most disadvantaged job seekers find and retain employment.[171]

4.195 Social Firms Australia (SoFA) was the recipient of $1 million in funding from DEEWR's Innovation Fund to carry out its Local Employment Access Partnerships (LEAP) for Job Seekers with Mental Illness.[172]

4.196 LEAP was a three year project that ran until June 2012. According to the SoFA website:

> During this time, 340 + job seekers with a mental illness will be supported to manage anxiety and other symptoms and improve job readiness skills to secure and sustain employment.[173]

4.197 The Social Firms Australia (SoFA) website outlines the premise and strength of the LEAP approach, which was established in six localities in Victoria, five in Melbourne and one in regional Victoria:

> LEAP partnerships promote service integration and provide wrap-around support for people with mental illness who are preparing for paid employment. The partnerships meet on a quarterly basis and also collaborate to deliver the Health Optimisation Program for Employment (HOPE).
>
> HOPE assists job seekers with a mental illness to take greater control of their wellbeing and has been adapted from an evidence-based psycho-educational program.
>
> HOPE is delivered jointly by a mental health peer educator and facilitator.[174]

4.198 Ms Dea Morgain, Manager, Workplace Supports, SoFA, elaborated:

> [LEAP] brings together the clinical mental health services, the rehab services and the employment services and provides the opportunity for those services to actually speak to each other outside of the requirements of case planning, so that there are established relationships...between clinicians and employment services...the discussions vary between the partnerships but they

171 DEEWR website, http://www.deewr.gov.au/Employment/JSA/Pages/innovationfund.aspx

172 See DEEWR website for details on the various Innovation Fund projects, http://www.deewr.gov.au/Employment/JSA/Documents/InnovationFundprojects.pdf viewed 23 February 2012.

173 SoFA website, http://socialfirms.org.au/what-we-do/leap-hope viewed 23 February 2012.

174 SoFA website, http://socialfirms.org.au/what-we-do/leap-hope viewed 23 February 2012.

undertake service-mapping, trying to identify gaps in service delivery.[175]

4.199 Ms Morgain later provided an independent evaluation from the company 'Effective Change' which found the successes and outcomes of the LEAP partnerships to be:

- Improved communication between agencies about strategies to assist job seekers with mental illness to achieve their vocational aspirations.
- Increased inter agency referrals and improved referral protocols. In one partnership this has resulted in the employment service locating an employment consultant at the mental health clinic.
- A better understanding on the part of mental health clinicians of the services provided by employment services, Centrelink procedures and vocational rehabilitation approaches. Improved knowledge of mental illness diagnoses, symptoms and treatments on the part of the employment services.
- All partner agencies have felt that the benefits of belonging to the partnership have significantly outweighed the time required to be involved.[176]

4.200 Ms Morgain added that while funding for the project ceases on 30 June 2012, the partner agencies from each area intend to continue meeting and SOFA will assist as resources allow.[177]

CRS , VETE and Headspace

4.201 Headspace was launched in 2006 and is funded by the Australian Government under the Promoting Better Mental Health –Youth Mental Health Initiative. There are 30 Headspace centres around the country, in each state and territory, metropolitan, regional and remote locations. These provide youth-friendly community based services to young people aged 12-15. All Headspace centres have a suite of services on offer, including allied health, drug and alcohol workers and mental health practitioners.[178] Centrelink and CRS are other services on-hand, specifically to help young people access education, training and work opportunities.

175 Ms Dea Morgain, Manager, Workplace Supports, SoFA, *Committee Hansard*, Melbourne, 19 August 2011, p. 25.

176 Email from Ms Dea Morgain, Manager, Workplace Supports, SoFA, *Exhibit 42*.

177 Email from Ms Dea Morgain, Manager, Workplace Supports, SoFA, *Exhibit 42*.

178 Headpsace, *Submission 13*, p. 2 and see Headspace website: http://www.headspace.org.au/headspace-centres

4.202 The Committee visited the Central Coast Headspace in Gosford on the same day that it visited Youth Connection's[179] Green Central site (see Chapter two for more on that visit).

4.203 In addition to Youth Connection, Headspace Gosford's other consortium partners comprise: NSW Government Health Central Coast Local Health District (the lead agency); NSW Government Central Coast Local Health Network –Central Coast Children and Young People's Mental Health (CC CYPMH); the NSW Government Central Coast Local Health Network – Area Drug and Alcohol Services – Central Coast Sector; Central Coast Division of General Practice; and The Brain and Mind Research Institute.[180]

4.204 Headspace is co-located with Y-Central at the Gosford site.

4.205 The Y-Central website sets out its mission:

> Y-Central is funded by NSW Health, through the Youth Mental Health Service Model – Central Coast pilot project.
>
> The CYMPH Program is oriented towards mental health promotion, prevention and early intervention. The program's youth-friendly venue, y-central, promotes easy access to mental health services for children (12-25years) and their families. There are also crisis entry points for children and young people to promote engagement and the provision of comprehensive assessments and appropriate management. [181]

4.206 Other services available to Gosford clients on-site include Wesley Mission's Get it together (GIT) program and a tenancy advisory service.[182]

4.207 Headspace was another strong advocate of integrated holistic services (drawing on and endorsing the research findings of other expert witnesses to the inquiry, such as Professor Killackey and Dr Geoffrey Waghorn).

4.208 Headspace pointed to the many benefits of having a vocational intervention co-located with a clinical service, including:

- [in relation to Killackey's 2008 study into a group of young people with first episode psychosis], that young people

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179 Youth Connections is an organisation that helps young people aged 11-19 years to access employment, education, training and recreational opportunities on the Central Coast. See the website for details: http://youthconnections.com.au/

180 Headspace Gosford website, http://www.headspace.org.au/headspace-centres/headspace-central-coast/consortium-partners

181 See Y-central website for more: http://www.ycentral.com.au/about-us

182 Y- Central website: http://www.ycentral.com.au/about-us

receiving this intervention were more likely to gain employment, worked more hours, earned more money and stayed employed longer than the group of young people who did not receive the vocational intervention; and

- [in relation to Waghorn and Drake's 2003 study], that integrated services have the following advantages:
  - ⇒ Lower client drop-out rate
  - ⇒ Clinical information gets into vocational plan preventing job loss
  - ⇒ Both health and vocational outcomes are optimised
  - ⇒ The clinical team can help with assessments
  - ⇒ Employment goals lever treatments; and
  - ⇒ Employment staff facilitate timely re-access to mental health services.[183]

4.209 Established in 2007 to provide employment and education support to people receiving community mental health services in the Northern Sydney and Central Coast regions, Vocational Education, Training and Employment (VETE) is part of Northern Sydney and Central Coast Local Health Districts. VETE consultants with experience from federally-funded employment programs are recruited and employed within health service funding.[184]

4.210 The service caters for people in the public mental health system, and seeks to improve their participation in education, training and employment.[185] A VETE employment consultant is co-located with the CC CYMH and Headspace precinct in Gosford, working two days a week with young people with a diagnosed mental illness.

4.211 VETE interventions are tailored to the individual and may include the following forms of advocacy and assistance:

- Vocational counselling
- Benefits counselling – to assist consumers understand Centrelink guideless regarding the number of hours they are permitted to work and the impact of income from employment on their Centrelink benefits
- Direct referral to Disability Employment Services
- Gathering supporting medical documentation required by consumers attending the Employment Services Assessment (DHS process)

183 Headspace, *Submission 13*, p. 9.

184 VETE, NSW Ministry of Health, *Submission 70*, pp.1-3.

185 VETE, NSW Ministry of Health, *Submission 70*, p. 8.

- Facilitating the communication of relevant disability related information between internal and external service providers
- Monitoring consumers rehabilitation progress once they have been linked with a suitable DES provider
- Supporting consumers to identify suitable courses and to enrol at educational institutions like TAFE
- Referral to specialist disability support services at TAFE and University
- Providing resources to clinicians and consumers regarding vocational/career/training information
- Assisting with the identification of suitable volunteer positions
- When required, developing plans with consumers to make a gradual transition towards employment taking into account their skills, mental and physical fitness, social and interpersonal skills and understanding of the labour market.[186]

4.212 VETE provided data indicating the numbers of people helped into employment, education and training, across all four sites, including Gosford.

4.213 VETE states that the following positive outcomes account for 70% of the 1776 individuals who proceeded with the VETE Service (out of 2000 referrals in the last 5 years):

Figure 4.3 Vocational Outcomes 2007-2011

Outcomes	Number of clients
Employment	246
Education / Training	218
Improved Vocational Skills / Resources	421
Linked with Employment Service Providers	257
Volunteer Work	53
Social Participation	42

Source VETE Submission 70, p. 8.

4.214 VETE pointed to an oversubscription of its Gosford service and the heavy workload to-date on its one part-time (0.4 FTE) VETE consultant:

> Since 2007, approximately 400 referrals for vocational and educational services have been received, which equates to 100 referrals a year. Data from Central Coast Headspace indicates that for the 12 month period from July 2010-to June 2011, there were 127 young people accessing Headspace who presented for mental health issues and also expressed an interest in or demonstrated a need for vocational services....[but] were not eligible for VETE

186 VETE, NSW Ministry of Health, *Submission 70*, p. 6.

> services because they did not meet the criteria for CCCYPMH. Using this as a guide, an increase in VETE would be warranted in order to provide vocational support for more young people.[187]

4.215 VETE highlighted the importance of inter-agency cooperation and network building between agencies providing vocational services for people with a mental illness:

> The aim of the partnerships is to break down barriers between organisations and share information of mutual benefit by having improved access to external programs, including TAFE and DES.[188]

4.216 VETE says it achieves this through regular interagency committee meetings and participation in a variety of separate meetings organised by external partners e.g. with Centrelink and the National Disability Coordination Officer.[189]

4.217 Underpinning the success of a co-located venture such as that between Headspace, Y-Central, VETE and various other service providers at the Gosford site, is an agreement between the parties to work together. Physical co-location may be an added benefit, but may not necessarily be critical. Ms Susan Robertson, Managing Director, Edge Employment Solutions suggested:

> I think the critical element is the agreement between the job seeker, their clinical provider and the agency all signing off on the need to contact each other regularly, and having that agreement in place at the outset. That will produce the best outcome. The co-location is just an added issue that may be a bonus or not.[190]

Orygen Youth Health - Individual Placement and Support (IPS)

4.218 Orygen Youth Health (OYH)'s principal recommendation to the committee was that:

> Mental health care and vocational support for young Australians with mental illnesses should be integrated and co-located in appropriately resourced youth platforms headspace and EPPIC.[191]

187 VETE, NSW Ministry of Health, *Submission 70*, p. 5.

188 VETE, NSW Ministry of Health, *Submission 70*, p. 7.

189 VETE, NSW Ministry of Health, *Submission 70*, p. 7.

190 Ms Susan Robertson, Managing Director, *Edge Employment Solutions*, Committee Hansard, 18 October 2011, p. 27.

191 Orygen Youth Health, *Submission 28*, p. 1.

4.219 Professor Eoin Killackey believes this is important because it is so difficult for people to have to navigate their way through separate services, mental health, and employment.[192] OYH claims that this difficulty is compounded by poor coordination between the two and the two different systems have two sets of priorities that may not always align.[193]Moreover:

> Employment is a key rehabilitative part of the process of someone's journey towards recovery; it is not something else.[194]

4.220 Orygen asserted that:

> Headspace for moderate to mild mental ill-health and EPPIC for serious mental illness –can provide this type of integrated clinical and employment support to young Australians. Currently these service platforms are not readily available to most young Australians who could benefit from them.[195]

4.221 As noted earlier in this chapter and in chapter one, the Commonwealth Government, through the federal budget, has recognised the utility of and committed additional funding to expand both the headspace and EPPIC models.

4.222 The OYH organisation, based in Melbourne, provides comprehensive clinical services to young people aged 12 – 25 years with mental health issues in the western and north-western areas of Melbourne. Their services include inpatient, acute, outreach, case-management, psychosocial programs, peer and family support.[196]

4.223 Professor Killackey, Director, Psychosocial Research, OYH, described the service further:

> It sees people from a catchment area of around one million people, of which around 250, 000 are in the age range from 15-25. Each year it receives around 2000 referrals and can take on around 700 of those people. It does that under two main areas. One is the early psychosis area, which is called EPPIC. The other area deals with

192 Professor Eoin Killackey, Director, Psychosocial Research, Orygen Youth Health, *Committee Hansard*, 13 April 2011, p. 18.

193 Orygen Youth Health, *Submission 28,* p. 3.

194 Professor Eoin Killackey, Director, Psychosocial Research, Orygen Youth Health , *Committee Hansard*, 13 April 2011, p. 18.

195 Orygen Youth Health Research Centre, *Submission 28*, p. 3.

196 Orygen Youth Health website, http://oyh.org.au/about-us

people who have non-psychotic illnesses, which is broadly called Youthscope, and there are a number of sub-clinics to that.[197]

4.224 The website for the Early Psychosis Prevention and Intervention Centre outlines the EPPIC program, namely that it is a dedicated early psychosis service within a dedicated youth service, Orygen Youth Health, and involved in research activities, primarily through the Orygen Youth Health Research Centre:

> The aims of EPPIC are:
>
> - Early identification and treatment of the primary symptoms of psychotic illness
> - Improved access to and reduced delays in initial treatment
> - Reducing frequency and severity of relapse, and increasing time to first relapse
> - Reducing secondary morbidity in the post-psychotic phase of illness
> - Reducing disruption to social and vocational functioning and psychosocial development in the critical period following onset of illness when most disability tends to accrue
> - Promoting well-being among family members and reducing the burden for carers
>
> The aims of treatment are:
>
> - Explore the possible causes of psychotic symptoms and treat them
> - Educate the young person and their family about the illness
> - Reduce disruption in a young person's life caused by the illness, restore the normal developmental trajectory and psychosocial functioning
> - Support the young person and their carers through the recovery process
> - Restore normal developmental trajectory and psychosocial functioning
> - Reduce the young person's chances of having another psychotic experience.[198]

4.225 OYH's research arm, the Orygen Youth Health Research Centre, has developed innovative service models and conducted leading research in

197 Professor Eoin Killackey, Director, Psychosocial Research, Orygen Youth Health, *Committee Hansard,* 13 April 2011, p. 12.

198 EPPIC website, http://eppic.org.au/about-us

the area of vocational rehabilitation for young people with psychosis and other mental illnesses. It is worth noting that OYH believes that many of the observations and recommendations it makes for this cohort would also be valid for older age groups too.[199]

4.226 The third tranche of OYH's work is its training and communications program which seeks to provide training and resources to improve the understanding of mental health issues in young people and to promote the capacity of the general public to support young people. OYH works with a range of organisations from health services, schools, drug and alcohol services, corporate organisations and sporting groups to achieve this.[200]

4.227 The Committee visited Orygen Youth Health premises on 12 April 2011 to meet with staff and clients.

4.228 Professor Killackey outlined OYH's research agenda and outcomes to-date. He said:

> We did the first-ever trial in the world of an employment intervention for young people with first episode psychosis, and following on from that we are doing a much bigger trial, which we just started recruiting for last week, that will be the biggest trial of its sort in the world and should give us a better ability to answer questions around the economics of this sort of intervention as well as answer things like: do people who get jobs use health services less, do they have fewer symptoms, do they use fewer drugs, do they just generally have better and more productive lives?[201]

4.229 Essentially:

> Research in Melbourne (by Orygen Youth Health Research Centre) and in the USA demonstrates that 85% of this group of young people can return to work or education if provided with an intervention that integrates in one service platform both timely, evidence based clinical care and intensive employment support.[202]

4.230 Orygen utilises the Individual Placement and Support (ISP) method of supported employment. ISP is a group of interventions that aims to helps

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199 Orygen Youth Health website, http://oyh.org.au/about-us and Orygen Youth Health Research Centre, *Submission 28*, p. 1

200 OYH website, http://oyh.org.au/about-us

201 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne, *Committee Hansard*, 24 March 2011, p. 1.

202 Orygen Youth Health Research Centre, *Submission 28*, p. 3.

people get into employment quickly and supports them there. It adheres to seven principles:

- Competitive employment
- Open to anyone, no work readiness assessment
- Immediate job searching
- Integrated within a mental health program
- Jobs based on consumer preference
- Time unlimited support
- Personalised benefits planning.[203]

4.231 Professor Killackey emphasised that IPS harnesses people's enthusiasm and clarified that Orygen offers 6 months of support, rather than time-unlimited support, for funding reasons.[204]

4.232 Early intervention is integral to the IPS model. Professor Killackey pointed to the potential to keep people away from going down the, potentially demoralising and dispiriting DSP path:

> Early intervention around these issues might actually circumvent some people- or perhaps quite a lot of people- starting on the DSP.[205]

> Being on a DSP is a safe place to be, but there would be very few people on the DSP, I imagine, who feel that they are achieving the potential that they wanted to achieve in their life.[206]

4.233 Professor Killackey indicated that the results so far are very promising. Referring again to their 85% success rate, and others, he elucidated:

> There is an average return across nine studies in the US, Europe and Asia of 61 per cent compared to 23 per cent in all the various control groups that they were using. There have been two randomised controlled trials in first episode psychosis now: ours and another one at UCLA. Ours got 85% back to school or work {out of 41 people in total: 20 and 21] and the one at UCLA got 83 per cent {out of 60 people: 30 and 30].[207]

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203 Orygen Youth Health, *Submission 28*, p. 6.

204 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne, *Committee Hansard*, 24 March 2011, pp. 5-6.

205 Professor Eoin Killackey, Director, Psychosocial Research, Orygen Youth Health, *Committee Hansard,* 13 April 2011, p. 18.

206 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne, *Committee Hansard,* 24 March 2011, p. 13.

207 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne, *Committee Hansard*, 24 March 2011, pp. 5-6.

4.234 Professor Killackey stressed that the improvement is significant:

> It is like a three –to fourfold difference.[208]

4.235 Ms Gina Chinnnery, employment consultant described her role at Orygen as 'finding people the kind of work that they want to do and following that up with support'.

4.236 Ms Chinnery described the support she offers, some of which she says might seem 'basic stuff' –be it how to answer the phone to dressing appropriately for interviews and obtaining a tax file number- but not to those who come from families who have only ever known being on welfare:

> With quite a few of the clients I work with, their parents have never worked-they have always been on the pension or the dole...so it is a real learning experience for them too.[209]

4.237 That said, she emphasised how keen most young people were to work, and were supported to do so by their families:

> They have volunteered for this service and they just want things to get moving as soon as possible...we kind of steer away from that prevocational job search training stuff, because you are just spending all this time talking and they are getting bored waiting.[210]

4.238 Miss A, a client of Orygen Youth Health said that, by contrast, her family had not been supportive, but she could rely on, and valued, her professional support networks.[211]

4.239 Professor Killackey commented on the intensive level of support provided during the six month period, and the subsequent trust and rapport built up between the employment consultant and client. One of the benefits of this approach is that it can act as an early warning system to detect and resolve any problems quickly:

> Quite often she will take people to work at the start and will be in close contact with them. Because she has achieved an outcome for them that they really quite value, quite often they will call her as a

208 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne, *Committee Hansard*, 24 March 2011, pp. 5-6.

209 Ms Gina Chinnery, employment consultant, Orygen Youth Health, *Committee Hansard*, 13 April 2011, p. 19.

210 Ms Gina Chinnery, employment consultant, Orygen Youth Health, *Committee Hansard*, 13 April 2011, p. 19.

211 Miss A, Committee Hansard, 13 April 2011, p. 19.

> first point of contact rather than their case manager., so she is aware of when things begin to deteriorate, quite often, earlier than the mental health system is and earlier than the employer. She is able to put in place a program to manage that. For some people that involves talking to the employer.[212]

4.240 In terms of scaling up Orygen Youth Health's employment consultant model, Professor Killackey said that his ARC funded study will determine the economic benefits or otherwise of so doing:

> We have just finished recruiting for that study, so it still has 18 months to run before we finish collecting that data...We did a really rough back of the envelope analysis after the first study, looking at how much it costs us to employ Gina and what outcome payments we would have got had she worked through the Job Network or one of the job service agencies. It pretty much just broke even. It is not a diligent economic analysis, but that is why I have involved economists in the ARC study.[213]

4.241 Professor Killackey said that they cap their case load for their employment consultant at 20: to give the client the individual support and attention that they really require, and it was on that basis that she broken even, but admitted that was financially difficult:

> We would probably struggle now, but that is more to do with the University of Melbourne's pay rises in the last few years than it is with the market rate for an employment consultant.[214]

4.242 Professor Killackey's observations are consistent with Dr Waghorn's findings that case loads in the employment services can be too high. In his experience, 25 or fewer per employment specialist tends to work very well. Dr Waghorn advised:

> What we find happens is that if we get the case load to 25 people or fewer, even if they have severe disabilities does not matter...We then get the employment specialist to adopt the evidence based practices and then do things with stuck clients, like not to ignore stuck clients. ..You need to be doing something with people every week..We have found that employment specialists who actually do

212 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne, *Committee Hansard,* 24 March 2011, p. 10.

213 Professor Eoin Killackey, Psychosocial Research, Orygen Youth Health, *Committee Hansard,* 13 April 2011, p. 20.

214 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne *Committee Hansard,* 24 March 2011, p,11.

> these practices and follow through with every client and provide good post-employment support service achieve way in excess of even the research expectations – 100 per cent employment outcomes is possible, even in impoverished labour markets. The Thames-Coromandel Peninsula in New Zealand is one really good example. ...there is almost no employer to be seen. There is the occasional run down corner store...You just cannot see any employers, but there is an employment specialist there, Workwise Employment Agency, who gets almost all of her clients into employment, every time. ...She gets to know everything in her territory and she is actively involved.[215]

4.243 While the studies have been with consumers with psychosis, Orygen opens that service up to its broader client base (which includes people with depression, anxiety and personality disorders) in between studies and has found that:

> Not that we have systematically evaluated that, but there seems to be a great deal of satisfaction of the case managers in those clinics that their clients are getting employment or education outcomes from that service.[216]

4.244 Orygen mentioned an interesting research gap, namely a lack of research on educational interventions. They say there is evidence to suggest that where education is included in an IPS approach that people make a transition from education to work. In a pilot study that Orygen completed with 19 young people, they found that with a similar approach to that taken for employment interventions, namely early intervention and intensive support, 18 of them achieved successful educational outcomes.[217]

4.245 Orygen would ideally like to see employment consultants funded as members of mental health services and that they be called vocational recovery or vocational rehabilitation services, thereby moving away from an association with disability terminology.[218]

4.246 The next section on state approaches will consider what New South Wales, Queensland and South Australia are doing in respect to integrating employment consultants in their public mental health services.

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215 Dr Geoffrey Waghorn RM, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, *Committee Hansard*, 9 August 2011, p. 14.

216 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne, *Committee Hansard*, 24 March 2011, p. 11.

217 Orygen Youth Health Research Centr*e, Submission 18*, p. 8.

218 Orygen Youth Health Research Centre, *Submisson 18,* 9.

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4.247 Professor Killackey of Orygen Youth Health told the Committee that he believed there was some fundng in New South Wales:

> I think there are about 20 people who work in the same capacity as Gina does across a number of mental health services, but as Laura [from Mental Illness Fellowship Victoria] said, what we probably really need is three or four people per mental service to do that.[219]

Queensland Health

4.248 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, spoke to the Queensland Government's commitment to placing employment specialists in a number of their mental health services.

4.249 Dr Groves described the Queensland Government's whole-of-government response, which targets people with a severe mental illness, in particular psychosis, because these are the people most likely to experience difficulty procuring employment, educational participation and social inclusion. However, he said the benefits extend more broadly to others with mental illness in the public mental health system. Overseeing this approach is a:

> ...peak government committee that consists of representatives from not only our education and training departments but also from [the Department of Employment, Economic Development and Innovation], Queensland Health, police, corrective services and Commonwealth Departments that are situated here in Queensland to make sure that all our programs can work together.[220]

4.250 Dr Groves backgrounded how, based on evidence from Dr Waghorn, and with drive and determination from consumer consultants (people in various stages of their own personal recovery who are now employed by Queensland Health), and also DES providers, Queensland Health had developed a pilot program called the Queensland Health Employment Specialist Initiative (Employment Specialist Initiative) in eight demonstration sites, spread across the state so that every district has a stake:

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219 Professor Eoin Killackey,Director, Psychosocial Research, Orygen Youth Health, *Committee Hansard*, 13 April 2011, p. 17.

220 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, *Committee Hansard*, 9 August 2011, p. 1.

> We gave funding to organisations to come and work within mental health teams. The idea was to try and break down the barriers- as much as with the mental health staff who probably have some of the most stigmatising attitudes toward people with mental illness in our community-about the issue of people with severe mental illness having the ability to go back into the workforce.
>
> [Consumer consultants] were the strongest advocates for saying to staff and to the DES providers, 'There are a whole bunch of people who really want to get a job; it is just that nobody has actually ever made those opportunities available to and open for them.' It probably took the best part of a year, but by and large that worked quite well in terms of breaking down some of those issues.
>
> The other thing that impressed us was that the feedback from the DEN providers, as they were then, was that to some extent we were probably the best value of money for them [because the clients wanted to work]..they came to us and said we actually do better with referrals from you that we do from other people who are coming out of other forms unemployment.[221]

4.251 The Employment Specialist Initiative co-located an employment consultant from a local DES in a public community mental health team to work collaboratively with consumers in helping to find work in the competitive employment market, using the evidence based supported employment model. Findings from the pilot included the following successful consumer outcomes:

- Increased independence, self-esteem and confidence;
- Increased sense of empowerment and control in life;
- Increased work skills and career opportunities;
- The development of new friendships; and
- Greater connectedness to the community.[222]

4.252 Dr Groves added:

> We have been able to get hundreds of people into some level of employment and some of them into full-time employment. This is for a group of people who most often the mental health service

221 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, *Committee Hansard*, 9 August 2011, p. 2.

222 Queensland Government, *Submission 56*, p. 47.

> would not believe they would have got any form of employment again. There are quite staggering case studies and histories.[223]

4.253 Queensland Health no longer funds this initiative, other than for research and collecting data, in order to 'better show the benefit of this' because:

> [Service providers] actually find it is a viable option for them in terms of their placements and the funding they get from the Commonwealth.[224]

Complex needs panels

4.254 Complex needs panels are another Queensland initiative. Dr Groves explained how they fit into the bigger picture of care-coordination:

> One of our [important whole –of-government approaches] is our care coordination approach where we have tried to get all those Queensland Government departments and those Commonwealth Departments that we can to agree to a common approach to taking away any barriers towards inclusion into programs. We noticed in 2006 when the COAG [mental health] plan was put in place that one of the common features was that different departments had different inclusion criteria and different exclusion criteria so somebody could be getting services from one government department but not form another. So we have developed MOUs and service agreements across all the Queensland Government departments to ensure that a particular group of people with the most complex needs get access to services as a priority, irrespective of where they might otherwise sit on a priority list. It has also been an important part of embedding that process that we have put in people in places to develop those relationships between service providers to ensure that if any gaps do crop up or if any barriers become apparent they are dealt with at the local level.[225]

4.255 Dr Groves set out how the 20 people employed as dedicated 'service integration coordinators' work across 17 districts in Queensland Health:

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223 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, *Committee Hansard*, 9 August 2011, p. 3.

224 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, *Committee Hansard*, 9 August 2011, p. 3.

225 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, *Committee Hansard*, 9 August 2011, p. 2.

> They set up a number of things, although complex needs panels are probably one of the most frequent things that they set up. Those people with the highest levels of needs – that is not everybody with a mental illness- can get referred to that panel. It is very good for sharing information without needing it to go through the usual blockages that the health system puts on sharing information with other agencies. That panel talks about what a person needs from more of a problem oriented approach than a symptom oriented approach. They key issue is identifying what types of services are required and how to provide them rather than what particular symptoms that a person has or obstacles that they face.[226]

4.256 One of the components key to the success of the care coordination approach appears to be obtaining senior leadership buy in. Queensland Government enlisted the support of director-generals of departments and regional directors and:

> In general, there is pretty good support for people to come.[227]

4.257 Another important factor is that:

> It is a very structured set-up which meets monthly and they are very committed stakeholders.[228]

4.258 The Committee met with members of the Gold Coast complex needs panel.

4.259 Ms Phyllis Quensier, Service Integration Coordinator, Gold Coast Health Service District, Queensland Health talked about the three panels that operate on the Gold Coast, catering for different demographics, and funded by various organisations. She explained that they are run separately, but panellists also work together and are 'constantly in touch':

> I believe we are quite unique in Australia on the Gold Coast because we actually have three panels that look at age groups from 10-64. I work for Queensland Health and I look at the 16-64 group with severe mental illness. Grant works for the Gold Coast Drug Council and he looks after the panel that looks at dual diagnosis between the ages of 17-29. Tanya is not here today, but

226 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, *Committee Hansard*, 9 August 2011, p. 4.

227 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, *Committee Hansard*, 9 August 2011, p. 4.

228 Mr Grant Robin, Program Director, Gold Coast Drug Council and Queensland Drug and Alcohol Council, *Committee Hansard*, 8 August 2011, p. 23.

> we have another group that looks at the younger group, 10-17...auspiced by Wesley Mission.
>
> We sit on each other's panels. We also have annual summits where we meet. About 70 people attended last time we had one. All the different coordinators and panels go there. We talk about capacities, any trends or issues that are coming up, what works and what does not work, and we might give a case-study to show people an example of what we do on the panel.[229]

4.260 Ms Quensier explained how they work:

> They are all different, but I have one for three hours once a month. I have had up to four new clients and about three referrals of that client at one meeting, which involves a lot of discussion. I have about 50 clients on the books now, which is a lot.[230]

4.261 Mr Robin added that sometimes clients attend, other times they do not. The referring clinician comes and the employment services. Ms Quensier commented that 'Centrelink come ad hoc but they need to be there more regularly.'[231]

4.262 Ms Quensier emphasised how critical the notion of partnerships is to the complex needs panel concept:

> Partnerships are the biggest help. The people who sit on the panel and are committed to the panel and want to help are the biggest support system that we have. It helps with access, it helps with streamlining referrals and follow-up and it helps with gaps. [An example is sharing knowledge of clients so that for instance someone on a younger age group panel can be transitioned to another panel once they reach the age of 18].[232]

4.263 Mr Tawanda Machingura, Assistant Director of Occupational Therapy, Gold Coast Health Service agreed:

> I just want to emphasise community partnerships and give an example of what we are doing in the Gold Coast service. We know that for someone to have success in employment it is because there

229 Ms Phyllis Quensier, Service Integration Coordinator, Gold Coast Health Service District, Queensland Health, *Committee Hansard*, 8 August 2011, p. 21.

230 Ms Phyllis Quensier, Service Integration Coordinator, Gold Coast Health Service District, Queensland Health, *Committee Hansard*, 8 August 2011, p. 24.

231 Ms Phyllis Quensier, Service Integration Coordinator, Gold Coast Health Service District, Queensland Health, *Committee Hansard*, 8 August 2011, p. 24.

232 Ms Phyllis Quensier, Service Integration Coordinator, Gold Coast Health Service District, Queensland Health, *Committee Hansard*, 8 August 2011, p. 22.

> are a number of services working together. If we have a barrier in one of those services, then we are unlikely to get a good employment outcome. One of the things we have done is to have employment services be available to clients within the mental health service itself, and that works so well because they are available and it improves access to those services.[233]

4.264 Mr Grant Robin, Program Director, Gold Coast Health Service District, Queensland Health, spoke on behalf of his panel, the Complex Needs Assessment Panel and Integrated Services (CNAPIS), which often has employment services make referrals to it:

> We engage them and have a look. I can give a family as an example..she had so many issues with regard to a DV situation. ..There are a whole lot of other priorities. We as a collective can sit around the table and say, 'Well, although she has come through an employment stream and she is kind of being mandated to find a job, otherwise there will be implications for her benefit..hang on a second, there is a whole lot of other priorities that we need to address, there is a lot of advocacy that needs to happen, there need to be referrals, there needs to be management not only of her situation as the primary referral but also in the context of the family system...That is the wonderful work we can do.[234]

4.265 Ms Christine Shaw, Acting Coordinator, Mental Health Recovery Program, Ozcare summarised the positive impact the panels had on one of her clients:

> My usual role is that of mental health support worker. ..I work directly with clients on the ground level. I referred a client to a panel and supported him with the panel. I just cannot emphasise how valuable it was for this person to be at the panel. Probably one of the biggest benefits for him was having a lot of trouble from different services that actually have the power to say right there and then, 'I'll do this; I'll do that, and it is done and followed through. If we were to try to access those people out in the community, it would probably take three weeks, or maybe longer, of trying to arrange appointments and a lot of anxiety and stress for the clients waiting for letters to come back...When we left there the client said he felt like a weight had been lifted from his

233 Mr Tawanda Manchingura, Assistant Director of Occupational Therapy, Gold Coast Health Service, *Committee Hansard*, 8 August 2011, p. 23.

234 Mr Grant Robin, Program Director, Gold Coast Drug Council and Queensland Drug and Alcohol Council, *Committee Hansard*, 8 August 2011, p. 23.

> shoulders and that he hoped for a good outcome. His issues have become manageable. So the panel was excellent for that.

South Australia Health- an integrated service delivery model

4.266 The Committee visited the Noarlunga Adaire Clinic, a specialist mental health service providing mental health care in the community in outer suburban Adelaide in South Australia. The clinic serves emergency presentations, first presentation of an early disorder (early psychosis) and clients who require mental health assistance for a period up to six months.[235]

4.267 Mr Todd Bamford, Team Leader, Transitional Care and Early Psychosis, and Noarlunga Emergency Mental Health Services, Southern Mental Health, Adelaide Mental Health Service, South Australia Health spoke to policy development work he did and the preparation of a discussion paper about the benefits of bringing into being an integrated service delivery model where employment and clinical mental health services work together to help clients with a mental illness:

> The discussion paper was intended as a synthesis of the evidence based around better employment outcomes for people with serious mental illness as well as triggering some thinking amongst the relevant stakeholders around what sorts of different ways of working we would need to adopt to actually implement the evidence based practices for employment outcomes.
>
> The evidence was very clear that an integrated service delivery model is far more effective when you are looking at hours worked and the length of time in employment, and even simply rates of consumers achieving employment...From the mapping we did, it did not look like we had anything like that evidence based model in existence...We brought together stakeholders from non-governmental employment services, non-governmental mental health services, clinical mental health services, consumers and carers, education providers and Centrelink.. We consulted around the State...We were talking about bringing together two very complex systems, the employment services sector and the health services sector. We needed those stakeholders to tell us about the

235 Noarlunga Health Services, http://www.noarlungahealth.sa.gov.au/services/pages/mhealth/6668/

> problems and then start working on the solutions. – and they did that.[236]

4.268 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health provided some context for Mr Bamford's paper, saying that it complemented an earlier *Stepping up* report of 2007 which set the platform for broad reform in South Australia's mental health system and the state's commitment to giving staff the tools and system design to provide the services to better consumer outcomes. He described the very dedicated way that Southern Mental Health approached change management:

> W really worked hard on developing role clarity. One of the most important things for our services in public mental health is to be clear about the service, the roles and the functions that we provide. And that was the same for the disability employment services because, again, if you want to start busting myths around what we do, the clearer we are with our roles and functions, the greater the opportunity to work together.
>
> We did a lot of training and training requirements.
>
> Information sharing was a big issue....obviously this is driven by consumer consent. We made sure that with consumer consent, our medical records, or out case notes, were accessible to the disability employment staff. We wanted to make sure each one of our consumers in the public sector has a care plan. The intent of that care plan is a consumer-driven care plan, but we wanted the employment part of our partnership to be reflected in each consumer's participation in that care plan.
>
> We made sure there were some shared values and a shared vision for case reviews.....Other things were conflict resolution, points of accountability and starting out an evaluation process, **ensuring and really supporting that employment is part of the rehabilitation journey that our services provide.**[237]

4.269 Mr Strachan highlighted the commitment they put into getting people on board with the new concept:

> Engagement with staff...the pre-staff surveys and the post-staff surveys we have done really reflect a robust uptake of what

236 Mr Todd Bamford, South Australia Health, *Committee Hansard*, 7 June 2011, p. 22.

237 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 23.

> people saw as a positive way to deliver more effective rehabilitation services.
>
> There was a strong investment in supporting families and cares to understand that this is a positive journey for their loved ones, not something that is going to make them lose their DSP or make them fall over and go into hospital.[238]

4.270 From the consultative process consensus on a service model and service-level agreement was reached.

4.271 Mr Strachan set out how the new service commenced in the Trevor Parry Centre, a residential community rehabilitation service for consumers with severe and enduring mental illness, and has since also been adopted by Club 84, another psychosocial rehabilitation program in the north-east.[239]

4.272 Mr Strachan reported encouraging results thus far. At Noarlunga, over the past 11 months, out of 21 residents that have gone through the centre, 14 have now registered with the Employment Access Service and are talking about their employment options. Nine consumers have completed a job capacity assessment. Six people applied for paid employment. Three have enrolled in further study or training. And, four people have commenced voluntary work. He said:

> We feel very proud of these outcomes because prior to this opportunity none of these consumers were actively working with us to access open and full employment.[240]

4.273 Of Club 84's outcomes he stated:

> They have got three hours a week with a disability employment service provider coming in and being part of the integrated team. They have had 20 consumers register with Employment Access. They have had eight complete a JCA. Five have completed resumes. They have had four who applied for paid employment. Six individuals attended interviews. We have had four who commenced and been successful in gaining paid employment, and this is full employment. We have had three who have undertaken further studying and training, and four who have undertaken and commenced volunteer work. So again, some really wonderful

238 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 24.

239 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 24.

240 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 24.

> outcomes and, again, working with those consumers with the most severe and enduring mental illness and disabilities associated with that.[241]

4.274 The success of this integrated employment service and clinical mental health service model is underpinned by an equally committed disability employment provider, in this instance, UnitingCare Wesley Port Adelaide Employment Access service:

> They really saw the benefit of participating in the change management approach to try and get an agreed shared vision; they saw that real need and the desire for change. I guess the important things from the UnitingCare Wesley Mission service provision was that they were the specialists that came in and were able to dispel an enormous amount of myth..including [dealing with] issues of disclosure in the workplace. **What we worked out and started to learn really fast was that, if we were able to respectfully disclose, with consumer consent, we could set up a really strong support system around that consumer and employer to make sure that we give that person every chance of genuine success in maintaining and sustaining their employment.**[242]

4.275 As with the Queensland model, teamwork is key. Mr Bamford elaborated:

> There is a relationship between the employment specialist and the mental health coordinator or the mental health specialist. When they are part of the same team....the relationship is ongoing and daily. That then overcomes the batching of all the big decisions to a three-monthly case conference or clinical review....There are multiple opportunities to influence that care plan.[243]

4.276 Also, like the Queensland model, the Southern Mental Health model has so far only dealt with and reached small numbers of people. Mr Strachan indicated that the potential is there to scale the model up and extend it to the far greater numbers of community-based clients who have a care plan but access it more infrequently:

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241 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 24.

242 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 25.

243 Mr Bamford, South Australia Health, *Committee Hansard*, 7 June 2011, p. 25.

> The potential is there. The desire is there. Our staff want it. Our staff keep asking for it. But it is capacity....[244]
>
> ...rolling it out to a community team with 500 consumers is taking a whole other journey.[245]

4.277 Mr Bamford intimated that this may not necessarily be a case of utilising further resources; existing ones may be sufficient. Nonetheless, an integrated model does require commitment and drive:

> ..for integration to happen, someone needs to support that integration – someone to actively support that change and then embed that change over time. John talked a bit about how they have done it with existing resources, and that is half a day a week from the employment specialist.[246]

4.278 The Committee can see the many benefits that a service model that integrates employment and clinical services can entail for the consumer but notes that to-date these have only operated on a small scale.

Recommendation 15

The Committee recommends that the Commonwealth Government explore ways, in partnership with the states and territories through COAG, to support Individual Support and Placement (ISP) and other service models that integrate employment services and clinical health services.

244 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 24.

245 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 27.

246 Mr Bamford, , Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 27.

5

Concluding comments

5.1 Amongst the general population up to a third of people have or will experience a period of mental unwellness in their lifetimes. This is reflected in the proportion of people on the disability support pension who have a mental illness (which is approximately 30 per cent). It is of great concern that these numbers appear to be on the rise. There are also people on other types of benefit who have undiagnosed mental health conditions. Co-morbidities like drug and alcohol addictions or homelessness can also mask mental illness.

5.2 This is not the first report to note the entrenched stigma surrounding people with a mental illness. Nonetheless, the Committee was struck by how pervasive stigma remains in schools, workplaces and the community as a whole. It is for this reason that this report's leading recommendation is that the Commonwealth Government coordinate a comprehensive and multifaceted national education campaign to target stigma and reduce discrimination against people with a mental illness in Australian schools, workplaces and communities. Organisations like Beyond Blue and Black Dog have done much already to raise awareness about depression and anxiety disorders. However, there is a need to complement this work with a targeted focus on the less well-understood mental illnesses such as psychosis.

5.3 High profile national anti-discrimination campaigns in other countries, including New Zealand, the United Kingdom and Scotland, have succeeded in raising awareness, countering stereotypes and changing attitudes about people with a mental illness. Engaging employer associations and employers is a core component of these international campaigns and is something to be emulated here.

5.4 The Committee believes that it is very important to start this work young, in schools. All the evidence points to the benefits of prevention and early intervention. In chapter two the Committee recognises this and recommends an extension of the Commonwealth Government's Kidsmatter Australian Primary Schools Mental Health Initiative, into high schools. Adolescence and early adulthood is often when mental illness first presents and it is a critical time to provide support. The expansion of the Early Psychosis Prevention and Intervention Centre (EPPIC) model as exemplified by Orygen Youth Health, Headspace and many other community organisations are examples of helping a range of young people to finish school and go onto further education or find work.

5.5 Ways to better assist students with mental illness needs to infiltrate into the country's universities and vocational and educational training institutions too. The Committee notes the good work done by student services and the increasing workload placed on disability liaison officers, in particular, with increased numbers of students having a mental illness. The educational institutions that are having the most traction in respect of helping students with a mental illness are the ones where university leaders acknowledge the issues, dedicate resources towards and support teaching and other relevant staff to assist students with mental ill health, rather than leaving these matters to student services. Encouraging and facilitating peer support groups on campuses is also extremely valuable.

5.6 Over and over, the Committee was told that people with a mental illness want to work, that it is part of their recovery. Work contributes to one's identity, sense of worth, purpose and stake in society. While social enterprises and schemes like supported wage systems have their place and certainly help some people enter into employment, the goal should be for people with mental illnesses to engage with the open employment market. Chapter three outlines a range of supports that exist to help job seekers and employers alike in this regard. Key to the success of any of these tools is an attitude of flexibility and a desire to make things work. Commonwealth initiatives like JobAccess, the Employment Assistance Fund and Jobs in Jeopardy appear to be underutilised and need to be promoted more widely, especially amongst employers, for greater take-up.

5.7 The Committee heard much from the supply side of the equation but less from employers. Employers who participated in the inquiry provided some outstanding model workplace strategies for employing and retaining employees with a mental health condition as well as looking after the mental health and wellbeing of all their employees. The Committee recognises that it may not have heard the full range of

employer experience because employers may not have had a positive or direct experience. Working with employers to promote the business case for employing someone with a mental illness is something that needs to happen, in both the public and private sectors.

5.8 The Commonwealth Public Service as a major employer in this country should be amongst those taking a lead role in exemplifying best practice.

5.9 The complexity of the Centrelink benefits system for Disability Support Pension recipients and its interaction with the employment services – both generalist and specialist (disability employment services) was repeatedly referred to and is considered in chapter four.

5.10 Contributing to this complexity is the plethora of welfare reforms in recent years, some of which have been introduced in stages and others that are still being transitioned in. There is a high degree of assessment and categorisation of people in the current system, with multiple players. These assessment processes need to be streamlined so that they are compatible and consistent across the services. A communications strategy that places consumers and the people who work with them at its heart is integral to ensuring that clients' employment and other services needs are met. The system and attendant processes should encourage and engage rather than discourage and disengage job seekers. On that note, participation requirements need to be sufficiently flexible for people to venture into employment, without fear of losing benefit entitlements and knowing that there is a safety net there for them should any particular job not work out.

5.11 Employment service providers that specialise in serving clients with a mental illness need to be recognised for the qualitative results they produce as well as quantitative ones. The quality of the job or educational opportunity matters. The aim should not be to get people into any job or training course for the sake of it. Disability Employment Service providers should be required to demonstrate their expertise in helping people with a mental illness find meaningful employment or educational and training opportunities, and this should be recognised in the Disability Performance Service Framework and star-rating system.

5.12 One of the main messages to come out of the inquiry is the importance of fostering case coordination and leveraging collaborative partnerships between government and other service providers, both formally and informally. The Committee was impressed by the breadth of strengths-building approaches being employed, especially the Individual Support and Placement (ISP) model that aims to get people into competitive employment as quickly as possible, with individualised support available

to the employee and employer alike, and the range of ways to bring employment services into clinical health services (sometimes, but not necessarily always co-located).

5.13 State governments, especially Queensland, are conducting some very interesting pilots in this area. However, there could be further research into identifying why they work so well, and, importantly, how they might be successfully scaled up across states and territories and the country as a whole. To this end, the Committee has recommended that the Commonwealth Government, in partnership with the states and territories, explore ways through the Council of Australian Governments (COAG) to support Individual Support and Placement and other service models that integrate employment services and clinical health services.

5.14 Clearly, having a third of people on the DSP with a mental illness not working is a huge economic impost. There are workforce shortages in parts of the country that need to be filled. There are economic benefits to greater inclusivity. And, it must be said this applies not just to people with a mental illness. In the current climate and into the future, workplaces need to be more, not less, flexible, adaptive and innovative in their approach to retaining healthy and vital workforces.

5.15 There is a lot of untapped human potential. The United Kingdom national campaign to end the stigma and discrimination experienced by people with a mental illness aims to 'start a conversation and empower people to feel confident talking about the issue.'

5.16 It is the Committee's hope that this inquiry contributes to a national conversation here in Australia. That discussion needs to involve all: the public, private and community sectors; educational institutions; and employers -together with individuals with mental illnesses, their families and carers. The statistics are such that even if we ourselves do not experience a mental illness, we will certainly know someone close who does. It is in everyone's interest to help job seekers with a mental illness secure sustainable employment. Many voices in this report show that there are effective ways to achieve this goal.

Amanda Rishworth MP

Chair

A

Appendix A - Submissions

1. Mr James Darcy
2. Sane Australia
3. Name withheld
4. Parliamentary-in-confidence
    - 4.1.1 Supplementary submission (also parliamentary-in-confidence)
5. Canefields Clubhouse Beenleigh Inc.
6. Parliamentary-in-confidence
7. National Disability Coordination Officer Program, Wodonga TAFE
8. National Disability Coordination Officer Program, SkillsPlus Ltd
9. Parliamentary-in-confidence
10. Welfare Rights Centre Queensland
11. Parliamentary-in-confidence
12. Name withheld
13. Headspace
14. Parliamentary-in-confidence
15. Dr Geoffrey Waghorn
    - 15.1 Supplementary submission
16. Black Dog Institute
17. Mental Illness Fellowship South Australia
    - 17.1 Suplementary submission

18. Mental Health Council of Tasmania
19. Parliamentary-in-confidence
20. Multicultural Mental Health Australia
21. beyondblue
22. Lantern
    22.1 Supplementary submission
23. Carers Australia and Carers New South Wales
24. Ms Ruth Tay and Mr Andrew Leigh MP
25. Name withheld
26. TEAMhealth
27. Open Minds
28. Orygen Youth Health Research Centre
29. TriQ
30. Private Mental Health Consumer Carer Network (Australia)
31. Occupational Therapy Australia
32. The WorkFocus Group
33. Psychosocial Research Centre
34. Workskills Incorporated
    34.1 Supplementary submission
35. National Disability Services
36. Queensland Alliance for Mental Health Inc.
37. Mental Health Coordinating Council
38. Social Firms Australia
39. Royal Australia and New Zealand College of Psychiatrists
40. The Australian Psychological Society
41. National Employment Services Association
42. NSW Consumer Advisory Group
43. Department of Human Services

44. Australian Human Rights Commission

45. Parliamentary-in-confidence

46. Janssen

47. Wesley Mission

48. ACE National Network

49. BoysTown

50. Tasmanian Government

51. Mr Jeff Munday

52. Bio-balance Health Association Inc.

53. Name withheld

54. Dr Richard Stuckey

    54.1 Supplementary submission

55. Name withheld

56. Queensland Government

57. Mental Illness Fellowship Victoria

58. Mr Stephen Brown

59. Associate Professor Vicki Bitsika

60. Mates in Construction

61. Ms Jeanette Thorogood

62. Department of Education, Employment and Workplace Relations, Department of Health and Ageing and Department of Families, Housing, Community Services and Indigenous Affairs

63. Medibank

64. Comcare

65. Name withheld

66. Edge Employment Solutions

67. Rio Tinto

68. Western Australian Chamber of Commerce and Industry

    68.1 Supplementary submission

69. Anglicare Tasmania
70. VETE (Vocational Education, Training & Employment) Service Northern Sydney & Central Coast Local Health Districts, Mental Health Drug & Alcohol, NSW Ministry of Health.
71. Australian Chamber of Commerce and Industry
72. Inspire Foundation
73. Australian Youth Forum
74. Commonwealth Ombudsman
75. Department of Education, Employment and Workplace Relations (DEEWR)
76. Department of Defence

B

Appendix B – Exhibits

1. Mr David Meldrum, Executive Director, Mental Illness Fellowship of Australia, Mental Illness Fellowship of Australia Inc., 'Mental Illness and Employment- challenges for the future', paper 4 in a series of 5 position papers to raise awareness of the needs of people with a mental illness in Australia (July 2010).
2. Professor Eoin Killackey, Orygen Youth Health, Miles Rinaldi et al, 'First episode psychosis and employment: a review', *International Review of Psychiatry,* April 2010; 22 (2): 148-162.

   Eoin J. Killackey et al, 'Exciting career opportunity beckons! Early intervention and vocational rehabilitation in first-episode psychosis: employing cautious enthusiasm', *Australian and New Zealand Journal of Psychiatry 2006*; 40: 951-962.

   Eoin Killackey et al, 'Vocational intervention in first-episode psychosis: individual placement and support v. Treatment as usual', *The British Journal of Psychiatry* (2008) 192, 114-120.
3. Mr Nick Rushworth, Executive Officer, Brain Injury Australia, Brain Injury Australia Inc., 'Complexities of co-morbidity (acquired brain injury and mental illness) and the intersection between the health and community services systems', A summary paper prepared for the Department of Families, Housing, Community Services and Indigenous Affairs, June 2007.
4. Ms Christine Emerson, Growing Towards Wellness Pty Ltd, funding submission to the Department of Health in Western Australia.
5. Ms Gina Chinnery, Youth Employment Consultant, Orygen Youth Health, Orygen Youth Health Research Centre, 'The relationship between violence and mental illness', Orygen e-Brief. February 2011.

6. Outlook, brochure, 'Bright ideas for an inclusive community.'
7. Ermha Inc., 'Madcap Enterprises exists to achieve one goal – to assist people with a mental illness who want to enter the workforce.'
8. Mind Australia, Strategic Plan 2010-2015, Mind Annual Report 2009-2010, and Sane Australia, Mindful Employer: Better workplace mental health, all related to Submission no. 2.
9. Nicholas Bolto, *The Difference,* Issue One....2011.
10. Email from name withheld, R. Perkins et al, 'Realising ambitions: Better employment support for people with a mental health condition', an independent review to [the UK] Government, Department for Work and Pensions, December 2009.
11. Dr Ellis Fossey, Psychosocial Research Centre, Ellie M. Fossey and Carol A. Harvey, 'Finding and sustaining employment: A qualitative meta-synthesis of mental health consumer reviews', *Canadian Journal of Occupational Therapy,* December 2010 77 (5) 303-313.

    Anne Williams, 'Sustaining employment in a social firm: views of employees with a psychiatric disability'.

    Tamar Paluch, 'What types of supports are available to employees in social firms', all related to Submission no. 33, all related to Submission no. 33.
12. Professor Helen Christensen, Director, Centre for Mental Health Research, Australian National University, a description of the Beacon Health Portal, developed by the Centre for Mental Health Research at the Australian National University.

    Helen Christensen and Ian B. Hickie, 'E-mental health: a new era in delivery of mental health services', **MJA**, Vol. 192 No. 11, 7 June 2010.

    Kathleen M Griffiths, Louise Farrer and Helen Christensen, 'The efficacy of internet interventions for depression and anxiety disorders: a review of Randomised controlled trials', **MJA**, Vol. 192 No.11, 7 June 2010.
13. A/Professor Peter Butterworth, Senior Research Fellow, Australian National University, P. Butterworth et al, 'The psychosocial quality of work determines whether employment has benefits for mental health: results from a longitudinal national household panel survey', *Occup Environ Med* (2011).
14. Mental Illness Fellowship South Australia, information folder, related to Submission no. 17.

15. Mr Todd Bamford, Team Leader, Southern Adelaide Health Service, 'Enabling Mental Health Consumer Employment Outcomes in South Australia', Discussion Paper, 3 June 2008.

16. Mr Deiniol Griffith, Team Leader, Mental Illness Fellowship of South Australia, various documents:

    Carmen C. D. Franke et al, 'Implementing mental health peer support: a South Australian experience', *Australian Journal of Primary Health,* 2010, **16**, 179-186.

    Emma Willoughby and Agravaine MacLachlan,' Effective consumer participation in organisational change.'

    MIFSA and Baptist Care SA, Peer work information, Information for organisations, brochure.

    MIFSA and Baptist Care SA, Employer tool-kit: Employing peer workers in your organisation

17. Mr John Strachan, Sector Manager, Department of Health, South Australia, powerpoint presentation, 'Enabling Employment Outcomes South Australia's Resume.'

18. Reverend Dr Keith V Garner, Superintendent/CEO, Wesley Mission, Architectural drawings for proposed Port Macquarie Clinic for Wesley Mission.

19. Mr Steve Bailey, Australian Psychological Society, Helen M. Stallman, 'Psychological distress in university students: A comparison with general population data', *Australian Psychologist*, December 2010; 45(4): 249-257.

20. Ms Georgia Zogalis, National Program Manager, Multicultural Mental Health Australia, brochure, 'National Cultural Competency Tool (NCCT) for Mental Health Services.'

21. Dr Philip Morris, 'Vocational rehabilitation in psychiatry – a re-evaluation (2008)'.

22. Ms Sarah Marshall, National Environment and Sustainability Manager, Abigroup Limited, DVD and CD, 'Building Strong Foundations'.

23. Ms Gail Middleton, Executive Director, Welfare Rights Centre Inc, brochure, 'Scene and Unseen.'

24. Mr Mark Hands, Executive Officer, Australian Trade and Industry College, information folder, 'The future of industry begins here.'

25. Mr Dale Dearman, School Counsellor, various documents:

Grace Lutheran College, school diary

'Healthy Minds Expo', Tuesday 19 July 2011, brochure

School Counselling Department, 'Mental Health And Well-being Initiatives Conducted by Grace Lutheran College'.

26. Dr Geoffrey Waghorn, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, various papers:

Geoff Waghorn et al, 'Building a career of your choice' 2nd ed., brochure funded by the Australian Government Department of Health and Ageing.

Geoff Waghorn and Chris Lloyd, 'The employment of people with mental illness,' *Australian e-Journal for the Advancement of Mental Health*, 4(2).

Geoff Waghorn et al, 'The importance of service integration in developing effective employment services for people with severe mental health conditions', *British Journal of Occupational Therapy*, July 2011 74 (7), pp. 1-9.

Deborah J. Browne et al, 'Developing high performing employment services for people with a mental illness', *International Journal of Therapy and Rehabilitation*, September 2009, Vol. 16, No. 9, pp. 502-511.

Deborah J. Browne, 'Employment services as an early intervention for young people with a mental illness', *Early Intervention in Psychiatry* 2010; **4**: 327-335.

Emma Robson et al, 'Preliminary outcomes from an individualised supported education programme delivered by a community mental health service, '*British Journal of Occupational Therapy*, October 2010 72 (10), pp. 481-486.

Geoff Waghorn et al, 'Reviewing the theory and practice of occupational therapy in mental health', *British Journal of Occupational Therapy*, July 2009 72 (7), pp. 1-10.

Geoff Waghorn et al, 'Earning and learning among Australia community residents with psychiatric disorders,'in press with *Psychiatry Research.*

Geoff Waghorn and Christine E. Spowart, 'Managing personal information in supported employment for people with psychiatric disabilities' in Chris Lloyd (ed), *Vocational Rehabilitation and Mental Health,* Wiley-Blackwell, 2011, pp. 201-210.

Geoff Waghorn et al, 'Enhancing community mental health services through formal partnerships with supported employment providers', in press with *American Journal of Psychiatric Rehabilitation.*

Gary Bond, 'Supported employment: evidence for an evidence-based practice, '*Psychiatric Rehabilitation Journal*, Spring 2004; 27, 4.

27. Ms Caroline Crosse, Executive Director, Social Firms Australia Ltd, various documents:

    Brochure, 'Health Optimisation Program for Employment: To help job seekers improve their mental health to get ready for work.'

    Powerpoint presentation, 'Local Area Employment Partnership (LEAP) and Health Optimisation Program for Employment (HOPE)- Results from first year of delivery.'

28. Mr Rick Kane, WISE Employment, Disability Employment Services, 'Job in Jeopardy Guidelines' effective date 14 February 2011.

29. Dr Jennifer Bowers, Chief Executive Officer, Australasian Centre for Rural and Remote Mental Health, information folder.

30. Northern Territory Government, The Office of the Commissioner for Public Employment, 'Willing and Able strategy 2009-2012: A strategy for the employment of people with a disability in the Northern Territory Public Sector.

31. Workfocus Group, Workfocus Australia and Disability Employment Services Factsheet on the National Disability Recruitment Coordinator, Service, and Factsheet on JobAccess: your one stop shot for disability employment matters.

32. Commonwealth Ombudsman, 'Falling through the cracks' Centrelink, DEEWR and FaHSCIA: Engaging with customers with a mental illness in the social security system', September 2010.

33. Comcare, brochure, 'Early intervention to support psychological health and wellbeing.'

34. Department of Defence, information folder on ADF mental health strategies, including a DVD, 'Dents in the Soul: dealing with post-traumatic stress disorder'.

35. Department of Education, Employment and Workplace Relations, 'OECD report: Sick on the job? Myths and realities about mental health and work.'

36. Dr Jennifer Bowers, Chief Executive Officer, Australasian Centre for Rural and Remote Mental Health, 'Road map' brochure.

37. Dr Jennifer Bowers, Chief Executive Officer, Australasian Centre for Rural and Remote Mental Health, 'Safety and health culture' brochure.

38. Email from Dr Laura-Anne Bull, Deputy-Registrar-Student Services, Australian National University.

39. Email from Ms Debi Toman, National Disability Coordination Officer, University of Sydney.

40. Email from Ms Nita Schultz, Executive Officer, Victorian TAFE Association.

41. Email from Ms Deepthi Wijesekera, Specialist Employment Services Group, Department of Education, Employment and Workplace Relations.

42. Email from Ms Dea Morgain, Manager Workplace Supports, Social Firms Australia

C

Appendix C – Hearings and witnesses

Thursday 24 March 2011, Canberra

Centre for Youth Mental Health

- Associate Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne.

Wednesday 13 April 2011, Melbourne

Mental Illness Fellowship Victoria

- Ms Laura Lee Collister, General Manager, Rehabilitation Services;

Orygen Youth Health

- Miss A, Ex-client;
- Ms Gina Chinnery, Youth Employment Consultant; and
- Associate Professor Eoin Killackey, Director, Psychosocial Research.

Sane Australia

- Ms Barbara Hocking, Director

Ostara Australia

- Mr Nicholas Bolto, Chief Executive Officer

Friday 13 May 2011, Canberra

International Society for Research on Internet Interventions

- Professor Helen Christensen, President

Mental Health Community Coalition ACT

- Ms Brooke McKail, Executive Officer

Vista Vocational Services

- Ms Bernette Louise Redwood, Executive Officer

Centre for Mental Health Research, Australian National University

- Associate Professor Peter Butterworth, NHMRC Principle Research Fellow.

Monday 6 June 2011, Whyalla

UnitingCare Wesley, Port Adelaide

- Mrs Marie Kuchel, Program Manager; and
- Mr Harry Marks, Business Supervisor, Wesley Social Enterprises.

Career Employment Group

- Mr Kevin Rogan, Chair, Regional Skills Formation Network, Whyalla office

Interwork Limited

- Mr Garry Velt, General Manager; and
- Ms Tracy Wilson, Employment Consultant.

Spencer Gulf Rural Health School, University of South Australia

- Ms Rose Hillman, Project Coordinator, Aboriginal Health; and
- Mr Kym Thomas, Coordinator, Aboriginal Health.

Tuesday 7 June 2011, Adelaide

Mental Illness Fellowship of South Australia

- Mr Deiniol Griffith, Team Leader, Peer Work Project;
- Ms Fiona Johnson, Team Leader, PHaMS West Program;
- Ms Natasha Miliotis, Chief Executive Officer;
- Ms Sarah Reece, Participant, PHaMs West Program; and
- Ms Lisa Thiele, Sessional Education Worker.

Private Mental Health Consumer Carer Network (Australia)

- Mr John Francis Kincaid, State Coordinator, South Australia; and
- Ms Janne Christine McMahon, Independent Chair and Executive Officer.

Southern Mental Health, Adelaide Health Service, South Australia Health

- Mr Todd Bamford, Team Leader, Transitional Care and Early Psychosis, and Noarlunga Emergency Mental Health Services; and
- Mr John Strachan, Acting Outer South Sector Manager.

Friday 17 June 2011, Sydney

Black Dog Institute

- Dr Caryl Barnes, Consultant Psychiatrist;
- Professor Vijayaa Manicavasagar, Director of Psychological Services;
- Mr Michael Hendrick Sluis, Community Programs Manager; and
- Ms Jacqui Wallace, Strategic Programs Manager.

Multicultural Mental Health Australia and Transcultural Mental Health

Macquarie University

- Mr Stephen Bailey, private capacity

Wesley Mission

- Mr Andrew Mitchell, Director of Mental Health, Employment and Counselling; and
- Mr Damien Munt, Operations Manager, Employment Services.

Carers NSW

- Ms Elena Katrakis, Chief Executive Officer;
- Ms Alison Parkinson, Policy Officer; and
- Ms Dianne Ross, private capacity.

NSW Consumer Advisory Group – Mental Health Inc.

- Mr Chris Hartley, Senior Policy Officer; and
- Ms Julie Hourigan-Ruse, Chief Executive Officer.

Monday 8 August, Gold Coast

Bio-Balance Health

- Mrs Judy Nicol, President; and
- Dr Richard Stuckey, Medical Representative.

Bond University

- Associate Professor Vicki Bitsika, Behaviour Management and Psychology, Associate Dean for Teaching and Learning, Faculty of Humanities.

Gold Coast Employment Support Service

- Mrs Melissa Williams, Manager.

FSG Australia en Vision Programs

- Miss Kerrie Banks, Service Manager; and
- Mr Daniel Menhennet, Intention Peer Support Worker.

Complex Needs Panel

- Mr Tawanda Machingura, Assistant Director of Occupational Therapy, Gold Coast Health Service; Division of Mental Health and ATODS, Queensland Health;
- Ms Phyllis Quensier, Service Integration Coordinator, Gold Coast Health Service District, Queensland Health;
- Mr Grant Robin, Program Director, Gold Coast Drug Council and Queensland Drug and Alcohol Council; and
- Ms Christine Shaw, Acting Coordinator, Mental Health Recovery Program, Ozcare.

Tuesday 9 August 2011, Brisbane

Queensland Government

- Dr Aaron Robert Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate; Queensland Health; and
- Mr Adam Stevenson, General Manager, Queensland Department of Employment, Economic Development and Innovation.

Queensland Centre for Mental Health

- Dr Geoffrey Waghorn RM, Head, Social Inclusion and Translational Research.

Queensland Alliance for Mental Health

- Mr Jeff Cheverton, Chief Executive Officer; and
- Ms Catherine O'Toole, President, State Council, and Chief Executive Officer, Advance Employment.

Welfare Rights Centre Inc.

- Ms Gail Middleton, Executive Director; and
- Ms Georgina Lawson, Project and Research Officer.

BoysTown

- Ms Tracy Adams, Chief Executive Officer;
- Mr John Dalgleish, Manager, Strategy and Research; and
- Mrs Anne McEachen, National Job Services Manager.

Abigroup Limited

- Ms Sarah Marshall, National Environmental and Sustainability Manager; and
- Mr Rhett Jayson, General Foreman, Queensland Children's Hospital Site.

19 August 2011, Melbourne

beyondblue

- Mr Brian Graetz, Program Director, Education and Early Childhood;
- Ms Therese Fitzpatrick, National Workplace Program Manager; and
- Mr Nicholas Arvanatis, Program Manager, Employment and Workforce.

National Employment Services Association Ltd.

- Ms Sally Sinclair, Chief Executive Officer.

Lantern

- Ms Janet Evelyn Bromley, Manager, Services; and
- Ms Elaine Patricia Gibbs, consumer.

Occupational Therapy Australia Ltd.

- Mr Chris Kennedy, Senior Policy Advisor; and
- Mr Geoff Lau, Chairperson, Queensland Division.

Social Firms Australia

- Ms Caroline Anne Crosse, Executive Director; and
- Ms Dea Coleen Morgain, Manager.

Australian Psychological Society

- Mr Bo Li, Senior Policy Advisor, Professional Practice; and
- Dr Rebecca Mathews, Manager, Practice Standards and Resources.

Tuesday 30 August 2011, Gosford

Fairhaven Services

- Ms Carlene Brzozowski, Learning and Development Officer; and
- Mr Jim Buultjens, Chief Executive Officer.

Employment and Training Australia

- Ms Petrina March, Business Development Manager; and
- Mr Tony Mylan, Chief Executive Officer.

The ORS Group

- Mrs Michelle Kathleen Bell, Assistant General Manager; and
- Mrs Anthea Smith, National Allied Health Manager.

Youth Connections

- Mr Ashley McGeorge, Transitions Manager;
- Ms Meredith Milne, Youth Transitions Executive Officer; and
- Ms Linda Thomas, Team Leader YC Program.

Thursday 22 September 2011, Canberra

Mission Australia

- Ms Kylee Bates, General Manager, Employment Solutions

Thursday 13 October 2011, Canberra

Department of Education, Employment and Workplace Relations

- Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group;
- Mr Graham Harman, Director, Disability Employment Service Performance Section, Disadvantaged Job Seekers Branch, Specialist Employment Services Group; and
- Ms Sharon Stuart, Branch Manager, Disadvantaged Job Seekers Branch, Specialist Employment Services Group.

Disability Employment Australia

- Mrs Donna Maree Faulkner, Chairperson of Board of Directors, and Executive Director, Work Solutions Gippsland;
- Ms Cherie Jolly, Delegate of member organisation UnitingCare Wesley Port Adelaide;
- Ms Margaret Liddell, Delegate of member organisation, UnitingCare Wesley Mission;
- Mr Keith Mahar, Ambassador; and
- Ms Lynette May, Chief Executive Officer.

Friday 14 October 2011, Canberra

Department of Education, Employment and Workplace Relations, Department of Health and Ageing and Department of Families, Housing, Community Services and Indigenous Affairs

- Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, Department of Education, Employment and Workplace Relations;
- Mrs Jill Farrelly, Branch Manager, Mental Health Branch, Department of Families, Housing, Community Services and Indigenous Affairs;
- Mr Evan Lewis, Group Manager, Disability and Carers, Department of Families, Housing, Community Services and Indigenous Affairs;
- Ms Phillipa Lowrey, Acting Assistant Secretary, Department of Health and Ageing;
- Ms Fiona Nicholls, Assistant Secretary, Department of Health and Ageing;
- Ms Sharon Rose, Branch Manager, Department of Families, Housing, Community Services and Indigenous Affairs;
- Mr Alan Singh, Assistant Secretary, Department of Health and Ageing; and
- Ms Sharon Stuart, Branch Manager, Disadvantaged Job Seekers Branch, Specialist Employment Services Group;

Department of Human Services

- Ms Malisa Golightly, Deputy Secretary, Health and Older Australians'
- Ms Dianne Fletcher, General Manager, Rehabilitation and Assessment Services; and
- Ms Melissa Lond, National Manager, Mental Health, Disability and Carers.

Department of Defence

- Mr David Morton, Director General, Mental Health, Psychology and Rehabilitation;
- Major General Gerrard Fogarty, Head, People Capability; and
- Mr Neville Tomkins, First Assistant Secretary, Defence People Solutions.

Commonwealth Ombudsman

- Ms Emma Cotterill, Acting Director, Social Support;
- Mr Peter Edwards, Director, Adelaide/Perth; and
- Mr Adam Stankevicius, Senior Assistant Ombudsman.

Comcare

- Ms Christine Bolger, Director, Work Health; and
- Mr Neil Quarmby, General Manager, Work Health and Safety Group.

Australian Chamber of Commerce and Industry

- Mr Stephen Bolton, Senior Advisor, Employment, Education and Training; and
- Ms Jennifer Lambert, Director, Employment, Education and Training.

Monday 17 October 2011, Darwin

Equity Services, Charles Darwin University

- Mrs Judith Mary Austin, Coordinator;
- Ms Kerrie Coulter, Disability Liaison Officer;
- Ms Edwina Jane Grose, Director;
- Mr David Munro, student; and
- Mrs Jean Packham, Student Counsellor Facilitator.

Carers NT

- Mr Garry Halliday, Chief Executive Officer;
- Mrs Hiltrud Kivelitz, Mental Health Coordinator; and
- Mrs X, Carer.

TEAMHealth Top End Association for Mental Health

- Mr Dale Campbell, Chief Executive Officer; and
- Ms Melissa Heywood, Director, Client Services.

Northern Territory Government

- Mr Richard Francis Ashburner, Senior Policy Officer, Mental Health Branch, Department of Health;
- Mr Rodney Cryer, Manager, Training Operations, Department of Education and Training;
- Ms Bronwyn Hendry, Director, Mental Health Services, Department of Health; and
- Ms Jenny Stephensen, Director, Strategic Workforce Planning and Development, Office of the Commissioner for Public Employment.

Tuesday 18 October 2011, Perth

Chamber of Commerce and Industry of Western Australia

- Ms Marcia Helen Kuhne, Manager, Industrial Relations Policy

Rio Tinto and Dampier Salt

- Mrs Denise Carole Goldsworthy, Managing Director, Dampier Salt; and
- Dr Andrew Porteous, Manager, Corporate Health and Safety, Rio Tinto.

WorkFocus Group

- Mr Michael Kolomyjec, Divisional Manager; and
- Ms Nicola Tuckwell, Divisional Manager.

Edge Employment Solutions

- Miss Nicole Cox, National Disability Coordination Officer;
- Ms Susan Kaye Robertson, Managing Director;
- Ms Rebecca Turpin, Job Coordinator; and
- Mr Gary Wanstall, private capacity.

Friday 4 November 2011, Hobart

Workskills Inc.

- Ms Rebecca Hanslow, Case Manager;
- Ms Helen Hudson, Senior Case Manager;
- Mr Lucas Mackey, Senior Case Manager; and
- Mr William (Bill) Parsell, Case Manager.

Tasmanian Polytechnic

- Mr Colin Baldwell, Student Counsellor;
- Ms Linda Glover, Disability Liaison Officer; and
- Mr Ciaran (Paul) Murphy, General Manager.

Department of Human Services

- Mr Peter Ball, Service Leader;
- Mr Alistair Bissland, Social Worker;
- Ms Desley Hargreaves, National Manager, Social Work Services;
- Ms Patricia McAlpine, Acting National Manager, Rehabilitation and Assessment Services; and
- Mr Niko Milic, Social Worker.

CRS Australia

- Ms Denise Frederick, Divisional Manager, Victoria/Tasmania;
- Ms Patricia McAlpine, Acting National Manager, Rehabilitation and Assessment Services; and
- Ms Alison McCann, National Manager.

Statewide and Mental Health Services, Department of Health and Human Services, Tasmanian Government

- Ms Jane Austin, Principal Policy Officer,
- Mrs Vicki Polanowski, Team Leader, Adult Community Mental Health East.

WISE Employment

- Mr Richard Anthony Kane, Policy Advisor;
- Ms Alexandra Newton, Program Manager;
- Mr Robert Priest, private capacity; and
- Ms Lois Webster, Case Manager.

Thursday 24 November 2011, Canberra

Centre for Rural and Remote Mental Health Queensland

- Dr Jennifer Bowers, Chief Executive Officer

D

Appendix D – Inspections

Tuesday 12 April 2011, Melbourne

- Orygen Youth Health
- Knox Transfer Station, Outlook Market
- MadCap Cafe
- EACH Employment Services; and
- Central East Whitehorse Personal Help and Mentors Program.

Monday 6 June 2011, Whyalla

- Areas of cultural significance to local Indigenous people; and
- Interwork Limited.

Tuesday 7 June 2011, Adelaide

- Adaire Clinic, Southern Adelaide Mental Health Service;
- Mental Illness Fellowship South Australia (Panangga).

Monday 8 August 2011, Gold Coast

- Australian Trade and Industry College (AITC); and
- Bond University.

Tuesday 9 August 2011, Queensland

- Grace Lutheran College, Rothwell Campus

Friday 19 August 2011, Melbourne

- Knox Community Health Centre

Tuesday 30 August 2011, Gosford

- Y Central, NSW Central Coast Children and Young People's Mental Health (CYPMH);
- Central Coast Laundry, Fairhaven Services; and
- Green Central.