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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.