Queensland Alliance
FOR MENTAL HEALTH INC.
Peak body for the mental health community sector

Queensland Alliance for Mental Health
Submission to Standing Committee

House of Representatives Standing Committee on Education and Employment

Inquiry into Mental Health Barriers to Education, Training and Employment Participation

April 2011

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Summary

Feedback from the community-based mental health sector in Queensland has substantiated the evidentiary barriers that people with a mental illness experience when accessing education, training and employment across Queensland.

In identifying ways to enhance access to and participation in employment of people with mental illness, Queensland Alliance for Mental Health has highlighted the interconnectedness between mental illness, unemployment, homelessness and social isolation, emphasizing the need to collaborate across sectors to effectively address these issues. In support of this, Queensland Alliance for Mental Health recommends the *Individual Placement and Support* model to support people with a mental illness to (re)gain employment.

In identifying strategies to improve the capacity of communities and employers to respond to the needs of people with mental illness, Queensland Alliance for Mental Health supports a multi-pronged approach, incorporating a *whole of community approach* for the promotion of good mental health at work, an *indicated early intervention approach* to support people who are at risk of leaving employment, and a *targeted approach*, such as *Individual Placement and Support*, to support the (re)integration of people with severe mental illness back into employment.

Queensland Alliance for Mental Health has also recommended that further actions be implemented to address stigma and discrimination in the workplace.

Background

Queensland Alliance for Mental Health is the peak body for the mental health community sector in Queensland. Queensland Alliance for Mental Health is an independent charity which represents over 200 community organisations working in mental health. Queensland Alliance for Mental Health envisages a community that values differences, promotes well-being and creates a sense of belonging. We aim to achieve this vision by influencing, connecting, strengthening and collaborating with our communities to improve mental health and well-being. Our membership is made up of a variety of organisations from all regions in Queensland, and ranges from large national organisations, to small, unfunded support groups in the community.

In forming our responses below, Queensland Alliance for Mental Health sought feedback from our member organisations on the three specific areas included within the Standing Committee's terms of reference;

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

Queensland Alliance for Mental Health has focused our comments primarily on the barriers people with mental illness experience with regard to participation in employment. Many of our member

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organisations provided additional feedback around the barriers their clients experience in accessing education and training – we have included their comments at the end of this submission

Barriers to participation in employment for people with mental ill health

The Australian Government's National Mental Health and Disability Employment Strategy[1] identifies and acknowledges some of the many barriers faced by people with mental illness in obtaining and maintaining employment. The strategy articulates the obvious benefits of employment, such as higher income and greater self esteem, but also acknowledges the impact employment has on connecting people with society and establishing friendships and support networks.

People with mental illness experience higher rates of unemployment and lower rates of labour force participation than any other disability group[2]. As a result, people with mental illness are among the most socially and economically marginalized members of the community.

Both national[3] and international[4] research suggests an overlapping set of barriers to sustainable employment for people with a mental illness. These barriers were reiterated in the feedback received from our member organisations, and are listed below:

- Community and workplace stigma;
- The impact of mental illness and associated treatment;
- Low expectations from professionals and providers (health, disability and employment);
- Financial disincentives, ie fear of losing DSP;
- Low literacy and numeracy issues;
- Lack of sector connectedness, ie, mental health and employment sectors working in isolation;
- Physical health problems;
- Drug and alcohol issues;
- Homelessness;
- Family breakdown;
- Social isolation.

Ways to enhance access to and participation in employment for people with mental ill health through improved collaboration between Government, health, community, education, training, employment and other services

In reviewing a number of recent, prominent policy documents regarding the factors contributing to and perpetuating disadvantage, it is clear that as a nation, we cannot continue to deliver siloed services to our most disadvantaged citizens. The following examples demonstrate the relationships and interconnectedness of mental illness, unemployment, homelessness and social isolation, providing a strong impetus to address these issues from a whole of Government, whole of community perspective.

- The Commonwealth Government's *4th National Mental Health Plan*[5] has adopted a population health framework. This framework recognizes that mental health and illness result from the complex interplay of biological, social, psychological, environmental and economic factors at all levels, and therefore the determinants of good mental health and mental illness are often outside

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the health system, including factors such as income, education, employment, and access to community resources.

- The New Zealand *Welfare Working Group*[6], established to examine ways to reduce long-term benefit dependency and promote better work outcomes for a range of disadvantaged New Zealanders, identified that many of the solutions to reducing long-term benefit dependency lie outside of the welfare system. In particular, the Group identified the education system and mental health services as needing to address shortcomings, as these have a direct and adverse effect on welfare dependency.
- In 2008, the Commonwealth Government commissioned a literature review[7] to identify good practice and 'what works' in relation to assisting people with mental illness into employment. This review of the literature clearly identified that "work is generally good for physical and mental well-being. Worklessness is associated with poorer physical and mental health and well-being. Work can be therapeutic and can reverse the adverse effects of unemployment".
- The Mental Illness Fellowship of Australia, in their paper *Mental Illness and Employment – Challenges For the Future*[8], also highlighted the benefits of employment to people's general well-being, "…employment makes a significant difference to the wellbeing of people with a mental illness by increasing their self-esteem, lowering levels of symptoms, contributing to them feeling less isolated, enhancing social skills and providing structure and purpose to everyday living".
- The Commonwealth Government's *The Road Home: A National Approach to Reducing Homelessness*[9] similarly identifies broader determinants that perpetuate homelessness, stating "Homelessness is not just a housing problem. Homelessness has many drivers and causes, including the shortage of affordable housing, long-term unemployment, mental health issues, substance abuse and family relationship breakdown".
- In their report *Health, Housing and Disability – A Queensland Perspective*[10], Queensland Shelter discusses housing as a key social determinant of health and a significant engine of social inequality, with unequal access to adequate affordable and secure housing being cited as a potential source of health inequality in Australia.
- The WISE Group[11], one of New Zealand's largest non-Government providers of mental health services, emphasizes that mental health and employment are intimately inter-related. "Unemployment can cause or exacerbate mental ill-health and conversely employment enhances well-being and is therefore 'active' treatment for people with mental health problems[12]".

The policy papers referenced above all demonstrate that by focusing only on a single area of disadvantage, we can only achieve limited gains. The relationships between mental illness, unemployment, homelessness and social isolation are such that focused efforts on one without considering the others, will be in vain, however, by simultaneously addressing each of these areas of disadvantage, at the policy, funding and service delivery levels, positive outcomes can be achieved across multiple areas.

Queensland Alliance for Mental Health asserts that an effective way to enhance access to, and participation in, education, training and employment of people with mental illness is to implement *Individual Placement and Support*, which, among other things, relies on collaboration between providers for its success. The *Individual Placement and Support* Model prioritises gaining employment

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early, taking a 'place then train' approach, in contrast to the more traditional approach of 'train then place'.

A Cochrane Review[13] in 2001 demonstrated that when compared with *Pre-Vocational Training*, people who received *Supported Employment* were significantly more likely to be in competitive employment at 12 months (34% *Supported Employment*, compared with 12% *Pre-Vocational Training*). Clients in *Supported Employment* also earned more and worked more hours per month than those in *Pre-Vocational Training*. Additionally, there was no evidence that *Pre-Vocational Training* was more effective in helping clients to obtain competitive employment than standard community care.

Further more recent research has demonstrated stronger support for the *Individual Placement and Support* Model. Randomized controlled trials across the United States, Canada, Hong Kong, Australia and Europe have compared the experiences of people under an *Individual Placement and Support* Model, with groups taking more traditional approaches to vocational rehabilitation (ie, services based on the 'train then place' approach). Across the research, sites that most closely followed the *Individual Placement and Support* Model achieved the greatest success with an average of 61% of participants in competitive employment, compared with 23% in sites that followed other approaches[14].

The Sainsbury Centre for Mental Health[15,16,17] has undertaken considerable research in this area, publishing a number of briefing papers discussing and encouraging the *Individual Placement and Support* Model as the preferred model of choice leading to the most successful outcomes. The foundations of the *Individual Placement and Support* Model are a focus on paid employment of the individual's choice, not sheltered work or lengthy job preparation, and support that continues after the person gets a job and that is provided together with clinical care and welfare benefits advice.

> *"In following people for 30 years and then following patients who are in dozens and dozens of research studies that are sent around, it's totally clear to me at this point that there's nothing about medications or psychotherapies or rehabilitation programs or case management programs or any other things that we study that helps people to recover in the same way that supported employment does*18*".*

The WISE Group[19] in New Zealand support and successfully implement the *Individual Placement and Support* Model. One of the key features of their success is the integration of specialist employment consultants with community mental health teams. "We are currently integrated with 30 clinical teams. Employment consultants are experienced workers with expert understanding of the issues and barriers that people who experience mental illness face in getting and keeping jobs". The WISE Group believe that there are real opportunities in linking health and employment services in a more effective way at a policy, funding and service level. The Group also highlights the real implications of not integrating mental health and employment services:

> *"Perhaps one of the most fundamental indirect barriers to achieving better employment outcomes for people living with mental illness lies in sector isolation and its correlates: poor Intersectoral collaboration, knowledge transfer, and a system that is often difficult to navigate for those it is intended to support. For example, mental health services continue to be isolated from employment services and vice versa. This means clinicians can be unaware of developments in the field of psychiatric vocational rehabilitation, and employment specialists can be unaware of*

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the latest clinical treatments that might address symptoms they regard as employment limitations".

The WISE Group has articulated their rationale as to why they support the integration and co-location of specialist employment consultants within mental health clinical and support teams:

- *The evidence shows that people achieve better employment outcomes with the support of programs that integrate employment services and mental health treatment, both primary and secondary;*
- *The process of obtaining and maintaining work can be seen as a treatment as well as an outcome;*
- *The chance of people in contact with mental health services obtaining and maintaining employment is increased when employment and multi-disciplinary teams are integrated and decision-making is shared;*
- *The work of employment consultants provides an additional resource for health staff and for individual client goals. Furthermore, over time, people depend less on the health system as they progress in their recovery process;*
- *People with mental health problems who are employed are less likely to relapse and less likely to be hospitalized and if they do, their duration of admission is shorter;*
- *The majority of people with mental health problems want to remain in or secure work – and the majority can if they are given the right kind of help and support;*
- *Many individuals with experience of mental illness identify employment as a critical ingredient in their recovery and their sense of community belonging. We know that participation in meaningful activity and having an opportunity to contribute to the broader community are cornerstones of the recovery process.*

The key principles of the *Individual Placement and Support Model* are listed below:

- Competitive employment is the primary goal;
- Everyone who wants it is eligible for employment support;
- Job search is consistent with individual preferences;
- Job search is rapid, beginning within one month;
- Employment specialists and clinical teams work and are located together;
- Support is time-unlimited and is individualized to both the employer and the employee;
- Welfare benefits counseling supports the person through the transition from benefits to work[20].

In addition to the seven principles identified above, a further four principles with the potential to enhance vocational outcomes have also been proposed[21]. These include the capacity to provide intensive on the job support; a multi-disciplinary team approach; an emphasis on the rehabilitation alliance; and the use of systematic stigma countering and disclosure strategies.

Queensland Alliance for Mental Health acknowledges that the *Individual Placement and Support* Model has been primarily supported by integrating and co-locating employment specialists with community mental health teams. In fact, a number of our member organisations have participated in the Integrated Employment Project[22] which co-located employment services within mental health services, and can attest to the positive client outcomes achieved through better integration of

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providers. However, we would assert that broader integration of employment specialists, for example within community-based services, would reach many more people. The National Survey of Mental Health and Wellbeing[23] reports that only 35 percent of people who experienced symptoms of mental illness in the 12 months prior to the survey accessed services. This means that the large majority (2.1 Million) did not access services, but perceived they had an unmet need[24]. We would argue that by locating employment specialists within the community, there is an increased likelihood that people with mental illness will access them.

Feedback from one of our member organisations who was involved in the Integrated Employment Project[25] supports the integration of providers, but also questions whether employment services should be co-located within hospital-based services. Regarding the Integrated Employment Project, a Worklink employee states:

> *"Worklink, along with a number of other DES services nationally, was a part of this trial and continues to use this integrated approach. Currently Worklink has one employment officer based in the mental health team in Cairns which has definitely strengthened the relationship between both services, however I am not fully convinced that they need to be based there… a visiting arrangement could also work to provide information on what Worklink has to offer, but the person would actually access Worklink's offices when ready to seek employment. This would still allow for the establishment of a strong relationship which I believe is the key."*

> *"…I have been giving much thought to the practice of using the mental health service for people's employment needs, and how this only perpetuates the isolation of people with mental illness. We have found that many of the people referred by the Mental Health Service would prefer to come to our office, rather than seeing the Employment Officer at the Mental Health Service. In saying this, I support all the other principles of the Individual Placement and Support Model."*

In terms of the key component that employment specialists and clinical teams need to work together, we would argue that w*orking together* can either be via direct co-location, or implementing effective communication protocols that result in enhanced intersectoral linkages. In their paper looking at enhancing employment services within the Australian service environment[26] King et al conclude that the co-location of clinical and employment services and the enhancement of intersectoral linkages between separately located clinical and employment services can both achieve better integration. Queensland Alliance for Mental Health would support the broader-reaching enhancement of linkages between providers, or the co-location of employment specialists within community-based services, rather than restricting specialist employment providers to being located within hospital services.

Feedback from one of our member organisations sums this up nicely:

> *"I would much rather see better collaboration and accountability between our service and existing providers and partnering with agencies with shared values and a commitment to the target group… I think a three-way model between community based mental health services, clinical services and employment services in the way to go… we all have something to learn from each other… there needs to be agreed protocols, regular meetings and reviews with consumers and carers."*

There are a range of programs delivered by the community-based mental health sector that offer both clinical and non-clinical supports to people with severe mental illness (eg, Personal Helpers and

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Mentors, Support for Day to Day Living in the Community). Queensland Alliance for Mental health would like to see the integration of employment specialists, either by co-location or enhanced intersectoral linkages, with mental health support programs delivered by community-based services.

Strategies to improve the capacity of individuals, families, community members, co-workers and employers to respond to the needs of people with mental ill health.

Queensland Alliance for Mental Health acknowledges that within the National Mental Health and Disability Employment Strategy[27], the Australian Government has highlighted the role that employers should play in increasing employment opportunities for people with disabilities, and has articulated specific actions it will support to increase these employment opportunities. However, as has been pointed out by the Mental Illness Fellowship[28], the Strategy fails to articulate targets, nor does it specify how it will measure improved outcomes for people with a mental illness.

Queensland Alliance for Mental Health supports a multi-pronged approach to increasing employment opportunities for people with mental illness, and would support the measurement of agreed outcomes for each of the strategies. We would support a *whole of community* approach for the promotion of good mental health at work, an *indicated early intervention* approach to support people who are at risk of leaving employment, and a *targeted* approach, such as *Individual Placement and Support,* to support the (re)integration of people with severe mental illness back into employment.

Queensland Alliance for Mental Health would also like to see some concerted efforts to address stigma and discrimination in the workplace. A recent survey by SANE Australia reports that up to 75 percent of people who have a mental illness experience stigma and, of these, 16 percent reported stigma in the workplace[29]. The National Mental Health and Disability Employment Strategy identifies that 40 percent of complaints received by the Australian Human Rights Commission and the State/Territory Equal Opportunity Commissions relate to employment issues[30]. Despite this, there is only a vague action proposed to address this – *Develop national approaches to help people with disability and mental illness engage in the workforce.* Queensland Alliance for Mental Health believe that more action needs to be taken to address this important issue, and would refer the Standing Committee to the 'Employer Attitudes to Employing People with a Mental Illness Project'[31], commissioned by the Australian Government as part of their commitment to the National Action Plan on Mental Health[32]. This project scoped the attitudes of 100 employers of varying sizes across a range of industry types. Some of the key themes are listed below:

- Employers were much more receptive to the idea of retaining an existing employee with mental illness than recruiting people with known mental illness;
- Employers were highly reluctant to recruit people with mental illness, even in the face of existing labour shortages;
- There is a significant difference in employers' willingness and attitudes in regard to recruitment verses retention of people with mental illness;
- The 'unknowns' of mental illness were highly off-putting to senior executives, but employers considered these barriers to be even more off-putting to direct managers and co-workers;

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- Employers expressed significant concerns that employees with mental illness could be disruptive, or could cost the organisation in terms of time, resources and lost business;
- The cover-all term 'mental illness', and the words 'mental' and 'illness', all had highly negative connotations for employers, including associations that specifically reinforced misleading assumptions about the unsuitability of people with mental health conditions as employees;
- A widespread and deep misperception was that people with mental illness are incapable, unpredictable and unreliable.
- Employers consistently believed that only once organisations become more comfortable with and adept at managing existing employees with mental health conditions with they be more open to recruiting others with mental health conditions.

The Project[33] went on to outline a number of issues and suggestions for consideration (see project report[34] for full list). Chief among these was *Education to Change Negative Assumptions*. Employers considered that significant prejudice, negative assumptions and expectations, among lower and middle managers and workers generally, deter decision makers from employing people with mental health conditions. The research suggested that communication strategies and interventions be developed in tandem with, and supported by, a wider education campaign aimed at addressing community prejudice against people with mental illness.

Queensland Alliance for Mental Health would encourage the Standing Committee to look further into the issues and suggestions that emerged from the 'Employer Attitudes' Project[35], and perhaps look at implementing a comprehensive program, aimed at employers, which firstly addresses the discriminatory attitudes towards people with a mental illness, and secondly, explore and highlights the productivity benefits of developing and sustaining a mentally healthy workplace.

Barriers to education and training for people with mental ill health

As stated above, Queensland Alliance for Mental Health has focused our comments to the Standing Committee primarily on the barriers people with mental illness experience with regard to participation in employment. The comments below are specifically focused on the barriers people with mental illness experience with regard to accessing and participating in education and training.

Queensland Alliance for Mental Health would encourage the Standing Committee to consider the comments provided by Worklink in Cairns, who have considered the barriers experienced by their clients, when accessing and participating in education and training:

Worklink is a Disability Employment Service which has been in operation since 1995. It is based in Cairns and provides employment, rehabilitation and training services to people with mental ill health.

Barriers to participation in education, training and employment of people with mental ill health.

- *Participants are financially disadvantaged and most education and training courses are out of their budget.*

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- *Funding is very limited within the Disability Employment Services (DES) programme to allow providers to give financial support to participants in order to participate in any education and training.*
- *Wage Subsidy for the DES programme to enable people with mental ill health to participate in employment is much less than the funds that are available for the Job Services Australia wage subsidy.*
- *The majority of trainers delivering the education and training courses are lacking the knowledge and understanding of mental illness and how that might impact on the person, for example, concentration issues. This lack of knowledge can impact on how they deliver the training and whether the person will successfully complete it.*
- *Subsidised training is limited. There is a need for more subsidised training to become available (Far North Queensland).*
- *Training in remote areas is limited. Need more access to training in remote areas (e.g. Yarrabah, Kuranda, Mossman, Atherton, Tully etc)*
- *Transport is a big issue. Maybe allowing some funding in particular training and education courses to give participants financial assistance to travel to and from courses.*
- *Stigma and lack of knowledge of mental illness is still a big issue. Awareness raising programs or anti stigma campaigns to demystify mental illness are greatly needed. Worklink has developed its own program, Managing Diversity – Mental Health in the Workplace aimed at employers, supervisor's manager's etc. to educate them and break down stigma.*
- *More access to counselling services to help with barriers faced by people with a mental illness to help them to maintain employment, training and education placement.*

Ways to enhance access to, and participation in, education, training and employment of people with mental ill health through improved collaboration between government, health, community, education, training, employment and other services.

- *Need more flexibility around the term "allowable break" in the DES program Deed to accommodate for participants who become unwell whilst participating in training, education or employment.*
- *Create a collaboration of services. Get all DES providers delivering DES within the same ESA to work together as one group to obtain greater training and employment opportunities. Collaboration between other services that DES providers deal with e.g. Mental Health Case Managers, Local GP's etc.*
- *Need to break down employer stigma. Worklink has developed its own program, Managing Diversity – Mental Health in the Workplace aimed at employers, supervisor's manager's etc. to educate them and assist in breaking down stigma related to mental health in the workplace.*

Strategies to improve the capacity of individuals, families, community members, co-workers and employers to respond to the needs of people with mental ill health.

- *Education (Breaking down the stigma). Encouraging the government to fund advertising campaigns to help reduce the stigma associated with mental health.*

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- *Community support services. There are too many gaps. (either age limits, carer limits, earning capacity etc)*
- *Community Support Services. On the other end of the scale, there are situations where participants are over serviced which hinders their recovery process because of this.*
- *More advertising of available community services to make the community itself more aware of what is available. Local TV or radio stations.*

Queensland Alliance for Mental Health would also encourage the Standing Committee to consider the comments provided by Darumbal Community Youth Services in Rockhampton, who have considered the barriers experienced by young people, when accessing and participating in education and training:

Mental health and its associated problems are a stratification in inequality, which arise as an unintended consequence of social process, the most basic element of social process is education, the linkage between amounts of schooling and the economic advancement of both individuals and communities. Research in numerous societies/communities shows a persistent link between those with limited education and disadvantage.

I believe our youth who have mental health problems, whether they are of a clinical or psychological nature have been overlooked. Obviously, they are people also.

For those currently in the workplace and struggling need a good deal of support and compassion, the Individual Placement and Support Model according to research seems to have achieved great success.

However what of our future workforce? The many youth disengaged from school are tomorrows unemployed. The backgrounds vary, youth mental illness needs as much support and compassion as those post school age. Supported education and training should also be a priority.

These young people know and live the reality of being outcasts in the community at large, whether directly or indirectly. The labels are many, they are from the low socio economic group, dysfunctional families. For Australia's first people there is also post Colonisation and Transgenerational Trauma.

There is no shelter accommodation for under 16 year olds, no diversionary centres and very few places for those who are severely handicapped mentally, when they exit special schools.

This is a real problem and needs to be addressed.

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