



FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

INQUIRY INTO WORKFORCE PARTICIPATION BY PEOPLE WITH MENTAL ILLNESS

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Functions of the Committee

Extract from the *Parliamentary Committees Act 2003*:

- S.11** The functions of the Family and Community Development Committee are, if so required or permitted under this Act, to inquire into, consider and report to the Parliament on:
- (a) any proposal, matter or thing concerned with—
 - (i) the family or the welfare of the family
 - (ii) community development or the welfare of the community
 - (b) the role of Government in community development and welfare, including the welfare of the family.

Committee Membership

Committee Members

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Mr Frank McGuire, MLA (Deputy Chair)	Broadmeadows
Mrs Donna Bauer, MLA	Carrum
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Dr Janine Bush	Executive Officer
Dr Michael McGann	Research Officer
Ms Stephanie Dodds (until 6 July 2012)	Administration Officer
Ms Natalie Tyler (from 9 July 2012)	Administration Officer

Terms of reference

That under s 33 of the *Parliamentary Committees Act 2003*, the Family and Community Development Committee is required to inquire into, consider and report no later than 30 September 2012* on workforce participation by people with a mental illness, and the Committee is asked to consider:

- a) evidence of the low rate of workforce participation of people with mental illness, and the social and economic costs involved;
- b) identification of the barriers that people with mental illness experience in gaining and retaining employment;
- c) the respective roles of, and collaboration between, local state and Commonwealth governments, business and community organisations in supporting the workforce participation of people with mental illness;
- d) the effectiveness of programs that aim to improve the workforce participation of people with mental illness, including best practice models;
- e) opportunities for tailoring education and vocational training for the needs of people with mental illness;
- f) effective measures to support employers to recruit, employ and retain people with mental illness;
- g) the role of mental health services, and general health and community services in improving the workforce participation of people with mental illness.

* On 7 December 2011 the Legislative Assembly amended the reporting date from 26 November 2011 to 30 September 2012.

Chair's foreword

Like all Victorians, people with mental illness want the opportunity to work, to have a strong and vibrant economy and to have choice in their employment.

People with mental illness bring significant benefits to workplaces and the community through their participation in employment. There is a strong social and economic basis for fostering their workforce participation.

Employment also has considerable personal benefits for people with mental illness, including social inclusion, a sense of purpose, financial security, and increased confidence. Participating in employment can contribute to recovery from mental illness.

Despite these benefits, people with mental illness are up to 50 per cent less likely than people with no mental illness to participate in the workforce.

To lift the rate of workforce participation, the Committee's report has suggested that the Victorian Government establishes a Mental Health Employment Strategy across public and private sectors.

In this report, the Committee recommends that the strategy focuses on ensuring opportunities in education, changing perceptions of mental illness in the workplace, providing diverse employment pathways, and fostering healthy and supportive workplaces. It also suggests a need to improve linkages between mental health and employment support services.

To provide leadership, the Committee has recommended that the Minister responsible for mental health lead the development, implementation and coordination of a Mental Health Employment Strategy, working closely with other government departments and stakeholders.

On behalf of the Committee, I would like express appreciation to those provided oral evidence and written submissions to this Inquiry.

The Committee benefited greatly from the generosity of those individuals and organisations in the social firms that the Committee visited. The personal stories of people with mental illness and the value of their employment contributed to the Committee's understanding of the importance of increasing opportunities for participation.

The Committee would also like to express its thanks to the staff of the Family and Community Development Committee—Executive Officer, Janine Bush, Research Officer, Michael McGann and Administrative Officers, Stephanie Dodds and Natalie Tyler for their hard work and support to the Committee.

Finally, I would personally extend my gratitude to the Committee Members, Frank McGuire, Donna Bauer, Andrea Coote, Bronwyn Halfpenny and Nick Wakeling for their dedicated approach to this Inquiry.

A handwritten signature in black ink, appearing to be 'Georgie Crozier', with a long horizontal line extending to the right.

Georgie Crozier, MP
Chair

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Glossary

Area mental health services (AMHS)—the network of public clinical mental health services. They are managed by a general health service that operate within defined geographical areas.¹

Competitive employment—employment in the open labour market rather than settings tailored to provide employment to people with mental illness or disability and where workers are paid at or above award wages.²

Council of Australian Governments (COAG)—the peak intergovernmental forum in Australia, comprising the Prime Minister, state premiers, territory chief ministers and the President of the Australian Local Government Association. The Council's role is to initiative, develop and monitor the implementation of policy reforms that are of national significance and require cooperation by all levels of government.

Disability—a disability arises when a person's 'physical, mental, intellectual or sensory impairments intersect with various barriers that may hinder the individual's full and effective participation in society on an equal basis with others.'³ The Committee recognises that many people with mental illness do not view themselves as having a disability. In the Victorian policy context, people with mental illness are often treated distinctly to people with disability. However, for some purposes such as Disability Employment Services and equal opportunity and anti-discrimination legislation, the term 'disability' may include people with mental illness.

Disability Employment Services (DES)—Commonwealth-funded employment support services delivered by a range of not-for-profit and for-profit providers that assist people with disability, injury or health conditions to prepare for, find and keep a job in the open labour market.

Early Psychosis Prevention and Intervention Service (EPPIC)—an integrated and comprehensive mental health service aimed at addressing the needs of people aged 15 to 24 years with emerging (first episode) psychotic illness. The service aims to facilitate early identification and treatment of psychosis and reduce the disruption to the young person's functioning and psychosocial development.

Employment—the Australian Bureau of Statistics follows international conventions in defining employment as 'work for one hour or more [per week], for pay, profit, commission or payment in kind in a job or business, or on a farm.'⁴ People who work one hour or more without pay are also considered employed provided that they work in a family business or on a family farm.

1 Department of Human Services (2009) *Because mental health matters: Victorian mental health reform strategy 2009-2019*. Melbourne, Mental Health and Drugs Division, Department of Human Services, State of Victoria, p.157.

2 Morgan, A.J., Wattreus, A., Jablensky, A. et al. (2011) *People living with psychotic illness 2010*, report for the Department of Health and Ageing, Commonwealth of Australia, p.152.

3 Department of Health and Ageing (2012) *Ten year roadmap for national mental health reform: Draft for consultation*. Canberra, Department of Health and Ageing, Commonwealth of Australia, p.37.

4 Australian Bureau of Statistics (2011) *Labour force, December 2011 (Catalogue. no. 6202.0)*. Canberra, Australian Bureau of Statistics, p.37.

Employment support services—the network of government-funded employment services, incorporating Disability Employment Services and Job Services Australia, which assist people to prepare for, find and keep a job in the open labour market. The Commonwealth Government is mainly responsible for funding and administering the employment support services sector.

Headspace centres—single service sites that provide mental health and related services to people aged 12 to 25 years. The services include integrated:

- primary care services
- allied health services
- mental health services
- drug and alcohol services
- vocational support services.

Joined-up approach—refers to a policy approach that features collaboration and partnership between government departments or between levels of government to achieve policy goals.

Labour force participation rate—a measure of workforce participation that refers to ‘the share of the working age population who are either in a job or actively looking for one.’⁵ The labour force participation rate among people with mental illness includes people with mental illness who are employed and those who are unemployed and looking for work.

Mental health services—services in which the primary function is specifically to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness and/or their families and carers. Mental health services are provided by organisations operating in both the government and non-government sectors, where such organisations may exclusively focus on mental health service provision or provide such activities as part of a broader range of health or human services.⁶

Mental injury claim—refers to occupational injury claims where the claim relates to a mental health problem or illness supposedly caused or exacerbated by a person’s work.

Peer support—social and emotional support, often coupled with practice support, which is provided by people who have experienced mental illness to others sharing a similar mental health condition.⁷

Psychiatric disability—refers to the effects of mental illness, which to varying degrees, can impair functioning in different aspects of a person’s life such as the ability to live independently, maintain friendships, or maintain employment.⁸

5 Abhayaratna, J. & Lattimore, R. (2006) *Workforce participation rates—How does Australia compare? Staff working paper*. Canberra, Productivity Commission, Commonwealth of Australia, p.1.

6 Commonwealth of Australia (2009) *Fourth national mental health plan: An agenda for collaborative government action in mental health 2009-2014*. Canberra, Commonwealth of Australia, p.84.

7 Commonwealth of Australia (2009) *Fourth national mental health plan: An agenda for collaborative government action in mental health 2009-2014*, p.85.

8 Department of Human Services, (2009) *Because mental health matters: Victorian mental health reform strategy 2009-2019*, p.161.

Psychiatric Disability Rehabilitation and Support Services (PDRSS)—PDRSS are a core component of mental health services in Victoria, complementing clinical mental health services. PDRSS are managed by non-government organisations and focus on addressing the impact of mental illness on a person's daily activities and the social disadvantage resulting from mental illness.⁹

Psychotic illness—a group of mental illnesses characterised by delusions, hallucinations, loss of motivation, and disorganised thought, speech and non-verbal communication. Psychotic illnesses include schizophrenia and bipolar disorder, among others.¹⁰

Severe mental illness—generally refers to psychotic illnesses such as schizophrenia and bipolar disorder that are characterised by a loss of sense of reality, auditory or visual hallucinations, thought disorder, and delusions. Sometimes the term is used in a broader way to include people with severe depression.

Social enterprise—business ventures that are:

- led by an economic, social, cultural, or environmental mission consistent with a public or community benefit
- trade to fulfil their mission,
- derive a substantial portion of their income from trade
- reinvest the majority of their profit/surplus in the fulfilment of their mission.¹¹

Social firm—a type of social enterprise that has the employment of people with disability or mental illness as its goal. Social firms are characterised by a supportive work environment in which between 25 to 50 per cent of employees have mental illness.¹²

Social inclusion—involves ensuring that all people have the opportunity and support they need to participate fully in economic and community life, develop their own potential and be treated with dignity and respect.¹³

Stakeholders—persons, groups or organisations with direct interest, including societies, bodies, parties, associations, institutes, businesses, companies, unions, clubs, corporations, government, customers and future discrimination.

Supported employment—refers to employment in which jobs are specifically tailored for people with mental illness or disability, and supports are built into the workplace environment to assist people in maintaining their employment. Workers in supported employment may sometimes be paid productivity based wages rather than award wages.

9 Department of Human Services, (2009) *Because mental health matters: Victorian mental health reform strategy 2009-2019*, p.161.

10 Morgan, Wattereus, Jablensky et al. (2011) *People living with psychotic illness 2010*, p.154.

11 Barraket, J., Collyer, N., O'Connor, M. et al. (2010) *Finding Australia's social enterprise sector: Final report*. Social Traders and the Australian Centre for Philanthropy and Nonprofit Studies, Queensland University of Technology, p.16.

12 *Submission 43*, Social Firms Australia, p.1.

13 Department of Health and Ageing, (2012) *Ten year roadmap for national mental health reform: Draft for consultation*, p.39.

Acronyms

ABS	Australian Bureau of Statistics
ACE	Adult community education
ADEs	Australian Disability Enterprises
AHRC	Australian Human Rights Commission
AHRI	Australian Human Resources Institute
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMHS	Area Mental Health Services
AND	Australian Network on Disability
APS	Australian Public Service
ASU	Australian Services Union
BCG	Boston Consulting Group
CAMHS	Child and Adolescent Mental Health Service
CATT	Crisis Assessment and Treatment Team
CBT	Cognitive behavioural therapy
CCS	Community Contact Service
CEO	Chief Executive Officer
COAG	Council of Australian Governments
DBI	Department of Business and Innovation (Victorian Government)
DEAS	Disability Employment Advisory Service
DEECD	Department of Education and Early Childhood Development (Victorian Government)
DEEWR	Department of Education, Employment and Workplace Relations (Commonwealth Government)
DES	Disability Employment Services
DHS	Department of Human Services (Victorian Government)
DMS	Disability Management Services
DoH	Department of Health (Victorian Government)
DoHA	Department of Health and Ageing (Commonwealth Government)
DPCD	Department of Planning and Community Development (Victorian Government)
DSP	Disability Support Pension

EACH	Eastern Access Community Health
EAPs	Employee Assistance Programs
EECV	Ethnic Communities' Council of Victoria
EO Act	<i>Equal Opportunity Act 2010</i> (Vic)
EPPIC	Early Psychosis Prevention and Intervention Centre
ERMHA	Eastern Regions Mental Health Association
ESC	Essential Services Commission of Victoria
ESS	Employment Support Services
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs (Commonwealth Government)
GPs	General practitioners
GRTHLC	Geelong and Region Trades Hall and Labour Council
HILDA	Household, Income and Labour Dynamics in Australia surveys
HOPE	Health Optimisation Program for Employment
HR	Human resources
ILMOs	Intermediate labour market organisations
ILO	International Labour Organisation
IPS	Individual Placement and Support
JiJ	Jobs in Jeopardy
JSA	Job Services Australia
JSCI	Job Seeker Classification Instrument
LEAP	Local Employment Access Partnership
MHCA	Mental Health Council of Australia
MHCC	Mental Health Coordinating Council
MHLC	Mental Health Legal Centre
MI Fellowship	Mental Illness Fellowship of Victoria
NCVER	National Centre for Vocational Education Research
NSMHW	<i>National survey of mental health and wellbeing 2007</i>
NSW	New South Wales
OECD	Organisation for Economic Cooperation and Development
OHS	Occupational health and safety
OHS Act	<i>Occupational Health and Safety Act 2004</i> (Vic)
OPA	Office of the Public Advocate
OYH	Orygen Youth Health
PDRSS	Psychiatric Disability Rehabilitation Support Services

PHaMs	Personal Helpers and Mentors Scheme
PRC	Psychosocial Research Centre
RANZP	Royal Australian and New Zealand College of Psychiatrists
RCSA	Recruitment and Consulting Services Association
SHIP	Survey of High Impact Psychosis
SMEs	Small-to-medium sized enterprises
SoFA	Social Firms Australia
SROI	Social return on investment
SVA	Social Ventures Australia
TAC	Transport and Accident Commission (Victoria)
TAFE	Technical and Further Education
UN	United Nations
UK	United Kingdom
US	United States
VECCI	Victorian Employers Chamber of Commerce and Industry
VEOHRC	Victorian Equal Opportunity and Human Rights Commission
VET	Vocational education and training
VETE	Vocational Education, Training and Employment
VIC	Victoria
VicHealth	Victorian Health Promotion Foundation
VICSERV	Psychiatric Disability Services Victoria
VMHCN	Victorian Mental Health Carers Network
VMHRC	Victorian Mental Health Reform Council
VPS	Victorian Public Service
WHO	World Health Organisation
YSAS	Youth Support and Advocacy Service

Executive summary

What I would suggest about employment in the workplace is that it plays a key role in recovery from mental illness. During mental illness you lose the attributes of self-worth and confidence, and work plays a fundamental role in assisting you regain those by providing a sense of purpose and a sense of meaning. It is also important in relation to dealing with and establishing social networks—that is, that feeling of social inclusion.¹⁴

Victorians want the opportunity to work, to have a strong and vibrant economy and to have choice in their employment.

People with mental illness share these desires and are equally as diverse as the broader community in their approaches to workforce participation. They value employment, want to remain in their existing job or pursue new career pathways. For those who have been out of work due to their illness, most want the opportunity to return to work.

There is a strong social and economic basis for fostering workforce participation by people with mental illness, who bring significant benefits to workplaces and the community through their participation in employment. These benefits include:

- Personal benefits—such as social inclusion, a sense of purpose, financial security, and increased confidence. Participating in employment can contribute to recovery from mental illness.
- Social benefits—such as gains to the community from the valuable knowledge, skills, and experience that people with mental illness contribute through their employment. Workforce participation contributes to reducing the social costs of mental illness, such as poverty, homelessness and social exclusion.
- Economic benefits—such as reduced government expenditure on health and welfare services and increased economic output over time.

Despite these benefits, people with mental illness are up to 50 per cent less likely than people with no mental illness to participate in the workforce.¹⁵ According to the Australian Bureau of Statistics (ABS), people with mental illness in Australia experience higher rates of unemployment and lower rates of labour force participation than those with a physical disability. In 2003, the ABS reported that the workforce participation rate for people with mental illness in Australia of 28.2 per cent was low in comparison to the rate for people with a physical disability (48.3 per cent) and people with no disability or mental illness (80.6 per cent).¹⁶

¹⁴ *Transcript of evidence 8*, Open Minds, 21 November 2011, p.4.

¹⁵ Department of Education, Employment and Workplace Relations (2009) *National mental health and disability employment strategy*. Canberra, Department of Education, Employment and Workplace Relations, Commonwealth of Australia, p.6.

¹⁶ Australian Bureau of Statistics (2004) *Disability, ageing, and carers Australia 2003 (Catalogue no. 4430.0)*. Canberra, Australian Bureau of Statistics. Reported in Department of Education, Employment and Workplace Relations (2009) *National mental health and disability employment strategy*, p.6.

The Committee identified that people with mental illness experience considerable barriers to their participation in the workforce. These include:

- Systemic barriers—including stigma and discrimination, inflexibility within workplaces, and issues accessing mental health and appropriate employment support services.
- Effects of mental illness—including the episodic nature of some mental illnesses and the impact that symptoms and medications can have on people's ability to function in their employment role.

This report makes recommendations to encourage the creation of pathways into employment for people with mental illness. It also recommends strategies for healthy and supportive work cultures that enable people with mental illness to maintain their employment.

Leading a response to increase workforce participation

The Committee determined that the Victorian Government has a key leadership role to enable Victoria to experience the benefits of increased workforce participation by people with mental illness.

To lift the rate of workforce participation across the private and public sectors, the Committee has suggested that the Victorian Government establishes a mental health employment strategy. The Committee recommends that the strategy focuses on:

- changing perceptions of mental illness in the workplace
- preventing people with mental illness from leaving work and education prematurely
- creating diverse and flexible employment pathways for people with mental illness
- improving linkages between mental health and employment services.

To provide leadership, the Committee has recommended that the Minister responsible for mental health lead the development, implementation and coordination of a mental health employment strategy, working closely with other government departments and stakeholders. To ensure the strategy is implemented, the Committee has proposed that the Victorian Government incorporates a monitoring framework.

Commonwealth and Victorian Government responsibilities

The Committee identified significant overlaps in responsibilities across the Commonwealth and Victorian Governments. Income support, employment services and primary mental health care rest with the Commonwealth Government. The Victorian Government is responsible for specialist mental health treatment services, occupational health and safety, and education and training.

Despite these demarcations, the Committee found both duplication and gaps in responsibility for workforce participation by people with mental illness across the two levels of government. It has recommended that the Victorian Government works with the Commonwealth Government to:

- identify areas of duplication and funding gaps across Victorian and Commonwealth-funded services and programs
- clarify the respective roles of the Victorian and Commonwealth Governments in relation to funding and administering mental health services and programs.

Ensuring opportunities in education

Participation in education and vocational training is a key determinant for most people's future job opportunities and career pathways.

People who experience mental illness early in life can experience considerable disruptions to their educational and vocational training pathways. These disruptions can have an enduring impact on a person's participation in the workforce and long-term career prospects. Re-engaging in education and training can be challenging after a lengthy absence.

Remaining engaged in learning

Young people who experience mental illness are less likely to complete secondary and post-secondary education than their peers.

To minimise disengagement from school and education pathways by young people experiencing mental illness, the Committee identified the importance of early intervention and specialist support.

In particular it recommended a number of early identification strategies, including:

- a strategy to monitor and evaluate the implementation of mental health promotion programs in schools
- an increase in mental health literacy training for young people in schools to enhance their awareness and up-take of available supports
- a strategy to support the education sector to identify the risk factors for mental illness, including building the skills of teachers in recognising mental health issues.

Re-engaging in education and vocational training

Providing pathways to re-engage in learning is often critical for people with mental illness who are seeking to re-enter the workforce yet have experienced disruptions to their education.

Re-engaging in education and training can be challenging for people with mental illness who have negative experiences in school and other education settings. Low self-esteem and self-confidence in learning environments are not uncommon for people who left their schooling prematurely.

The Committee identified a need for specialised support to assist people with mental illness to re-engage with education and training.

Existing programs to assist people with mental illness in returning to learning have operated on a relatively small scale and the successfulness of approaches has still to be fully demonstrated.

The Committee has recommended that the Victorian Government develop a strategy to increase understanding of effective programs that support people with mental illness in returning to education and training. As part of this, it has recommended:

- developing and trialling models of flexible course delivery for vocational education and training (VET) students with mental illness

- assessing the potential for tailored support interventions (such as Individualised Placement and Support approaches) to assist people with mental illness in returning to education
- comparing the cost-effectiveness of different programs and interventions.

Changing perceptions of people with mental illness in employment

Public awareness of mental illness has increased over the past decade. Campaigns by organisations such as SANE and *beyondblue* that aim to reduce stigma associated with depression have contributed to greater understanding in the broad community of mental illness.

The Committee identified, however, that in the workplace awareness of mental illness is low. It determined there is a need to improve understanding of mental illness in the workforce and to change perceptions of people with mental illness. Most notably, understanding of psychotic illness remains particularly low in workplaces, and also the general community.

A fear of stigma can lead many people to keep their mental illness hidden within the workplace. The complexities associated with the disclosure of mental illness in workplaces can have implications for providing appropriate supports for people in employment during times when they are unwell.

People with mental illness can be overlooked for recruitment and promotion due to misconceptions about their ability to cope with the demands of work. Some employers also believe that employing people with mental illness will contribute to increased costs and risks for businesses.

The Committee determined that a targeted, multi-pronged strategy is needed to change perceptions and behaviours towards people with mental illness in the workplace. Such a strategy could also promote the business and community benefits of recruiting and retaining workers with mental illness.

The Committee has recommended that a multi-pronged strategy strives for cultural change in workplaces by:

- promoting positive perceptions of the employment of people with mental illness through awareness-raising and community education initiatives
- a program for employers with positive experiences to champion the employment of people with mental illness
- providing practical guidance and support to employers in relation to recruiting and retaining employees with mental illness.

It also determined that the Victorian and local governments can contribute to cultural change in this area through championing the employment of people with mental illness in public sector recruitment.

Providing diverse employment pathways

Like the broader community, the needs and aspirations of people with mental illness in the workplace are diverse.

The effects of mental illness on functioning in the workplace vary considerably depending on each person's individual circumstances. A person's capacity for work can also change depending on the stage of the illness and/or any medication they may be taking.

To support people to return to work or to maintain their existing employment, the Committee identified there is a need for flexible employment pathways. Flexibility is needed in mainstream employment. Flexibility can also be achieved by providing supported employment pathways.

Mainstream employment and mental illness

Providing flexibility to meet increased workforce participation by people with mental illness in mainstream employment involves supporting both employers and employees.

For some people with mental illness, returning to work may involve a staged return to work. Initially they may not have the capacity to work full-time and require some flexibility in their work arrangements.

The Committee identified that not all employers understand how to best manage and accommodate mental health issues within workplaces.

Employers often require support to understand how to effectively recruit and retain workers with mental illness. Many supports and information services are funded by the Commonwealth Government to assist in employing people with mental illness.

The Committee found that awareness of information and support services among employers is very low. It has recommended that the Victorian Government works together with the Commonwealth Government to develop a campaign to increase awareness of existing information services and supports.

The Committee has also recommended that the Victorian Government work in partnership with relevant stakeholders to develop a training strategy to up-skill employers and managers in working with employees with mental illness and how to provide suitable workplace adjustments. As part of this strategy, it has recommended:

- incorporating mental health literacy training within human resources and management training curricula
- engaging industry groups to promote the up-take of workplace mental health literacy training programs among members.

Supported employment

For some people with mental illness, supported employment options provide a valuable way to re-enter the workforce and to gain skills and experience.

Supported employment options can provide a highly flexible and supportive work environment that enables people with mental illness to re-enter the workforce at a pace that suits their capacity. Social firms can provide an ideal work environment for people with mental illness in these circumstances.

Some people transition to mainstream employment after a period of employment and training in the supportive work environment of a social firm. Others remain in social firms for longer periods.

The Committee identified that social firms are still an emerging sector and that further understanding is needed of the effectiveness of social firms as transitional employment pathways.

It has recommended that the Victorian Government undertakes a review of the social firm sector to determine the commercial viability of the sector and the success of social firms in transitioning people with mental illness into sustainable jobs in the open labour market.

Social procurement

Social procurement involves the use of purchasing power to create social value. This can include the creation of employment for disadvantaged workers in addition to acquiring goods or services.

In fostering diverse and flexible employment options for people with mental illness, the Committee identified that the Victorian Government and local councils can use social procurement to support employment options for people with mental illness.

The Committee has recommended that the Victorian Government proactively supports social procurement through businesses employing workers with mental illness by:

- providing information to government departments and local councils about the social value of procuring goods and services from businesses that employ people with mental illness
- increasing awareness of social firms and enterprises that can supply goods and services to government departments and local councils
- working with government departments and local councils to identify opportunities to procure goods and services from businesses employing people with mental illness.

Fostering healthy and supportive workplaces

Unhealthy workplaces can contribute to the development of mental illness. Unhealthy workplaces can have cultures of bullying and stress through unreasonable job demands.

The Committee identified the importance of fostering healthy and supportive work environments to prevent mental illness injuries and to effectively support people who experience mental illness during their employment. It found that there are considerable financial benefits for organisations and businesses that achieve healthy workplaces.

The Committee has recommended the Victorian Government promotes healthy and supportive workplaces by:

- working with employers to increase awareness and improve responses to work risks for mental health, such as bullying and job stress

- developing and implementing a campaign that highlights:
 - the benefits of early intervention in the context of work-related mental health problems
 - the productivity and health costs associated with work-stress and other psychosocial hazards
 - the value in workplaces providing counselling support and stress management training.

Another early intervention approach considered by the Committee was the benefits of incorporating checks for mental health into the WorkSafe *Work health checks* scheme. The Committee has recommended that the Victorian Government undertakes a pilot study to evaluate the feasibility and benefits of this approach.

The Committee determined that there is a role for interventions such as counselling and support in the workplace to minimise risks of mental health injury. It identified a need for greater awareness of existing services, such as Employment Assistance Programs (EAPs).

To ensure EAPs provide the greatest benefit to people with mental health problems, the Committee has recommended the development of industry-wide standards for EAP providers for responding to and supporting employees that present with mental health problems.

Working with relevant stakeholders to evaluate existing return to work guidelines for employees who have taken leave due to mental illness and increasing awareness of effective return to work guidelines

Strengthening mental health services

Mental health services have a critical role in supporting the education and employment goals of people who use their services.

The Committee identified there is value in increasing the focus of mental health services on education and employment goals, particularly those involved in recovery planning for people with mental illness.

To increase understanding of the importance of workforce participation in recovery for people with mental illness, the Committee has recommended that the Victorian Government develops a professional development program for mental health practitioners.

It has also recommended that as part of the mental health reforms underway in the state, the Victorian Government:

- establishes clear targets for Psychiatric Disability Rehabilitation and Support Services (PDRSS) for achieving education and employment goals
- increases the availability of evaluated programs that train peer workers to work in mental health services to provide support to people with mental illness in their recovery and workplace participation.

Linkages across mental health and employment support services

The Committee identified that a key challenge that jobseekers with mental illness frequently experience is negotiating two service systems that can often have incompatible objectives. These are the:

- Commonwealth-funded employment support services system
- Victorian Government-funded specialist clinical and recovery mental health services.

The Committee determined a need for greater integration and more complementary objectives across these two systems.

It found that coordination across sectors is most effective when services are jointly delivered and employment support is integrated with clinical care.

In particular, it identified that locating employment consultants in early intervention services in the mental health sector provides an integrated approach that has the potential to deliver significant benefits to people with mental illness with education and employment goals. It has recommended that the Victorian Government works with the Commonwealth Government to integrate vocational support within early intervention focused mental health services.

The Committee also identified that cross-sector networks can potentially improve joined-up practices across the service systems. These locally based networks aim to facilitate knowledge sharing and actively refer people to agencies across the specialist mental health and employment support service systems.

It has recommended that the Victorian Government prioritises the development of more local partnerships between specialist mental health and employment support services.

List of recommendations by chapter

Chapter 1: Experiences of people with mental illness

No recommendations.

Chapter 2: The case for increasing workforce participation

- 2.1 That the Victorian Government takes a lead role in liaising with the Commonwealth Government and the Australian Bureau of Statistics (ABS) to establish a consistent approach to defining people with mental illness in surveys for the purposes of measuring unemployment and labour force participation rates among people with mental illness.
- 2.2 That the Victorian Government evaluate the increased social benefits and value for spend delivered by programs that decrease recidivism.

Chapter 3: Leading a response to increase workforce participation

- 3.1 That the Victorian Government takes a lead role in liaising with the Commonwealth to:
 - Minimise duplication and funding gaps across Victorian and Commonwealth-funded services and programs.
 - Clarify the respective roles of the Victorian and Commonwealth governments in relation to funding and administering mental health services and programs.
- 3.2 That the Victorian Government develops a mental health employment strategy that outlines its forward plan to increase workforce participation by people with mental illness with the capacity to work from 29 to 50 per cent across the public and private sectors by 2020 through:
 - Changing attitudes towards mental illness and the employment of people with mental illness.
 - Preventing people with mental illness from leaving work and education prematurely.
 - Creating diverse and flexible employment pathways for people with mental illness.
 - Improving linkages between mental health and employment services.
- 3.3 That as part of the Strategy planning process, the Victorian Government incorporates an implementation plan and monitoring framework into the Strategy to specify how its goals will be achieved and monitor its achievement.

- 3.4 That the Minister responsible for mental health takes the lead in overseeing the development, implementation and coordination of a mental health employment strategy, working closely with other government departments and stakeholders.

Chapter 4: Ensuring opportunities in education

- 4.1 That the Victorian Government establishes a strategy to monitor and evaluate the implementation of mental health promotion programs in schools.
- 4.2 That the Victorian Government increase mental health literacy training for young people in schools through programs such as *Live4Life* to enhance their awareness and up-take of supports available, and to reduce the stigma associated with mental health issues.
- 4.3 That the Victorian Government develops a strategy to support the education sector to identify the risk factors for mental illness, including:
- Enhancing skills of teachers, guidance counsellors and other education professionals to recognise and respond to the symptoms of mental illness.
 - Incorporating Mental Health First Aid as part of teacher training.
 - Identifying, raising awareness and increasing relevant service support.
- 4.4 That the Victorian Government develops a strategy to increase understanding of effective programs that support people with mental illness in returning to education and training, including:
- Developing and trialling models of flexible course delivery for VET students with mental illness.
 - Assessing the potential for Individualised Placement and Support (IPS)-style interventions to support people with mental illness returning to education.
 - Comparing the cost effectiveness of different programs and interventions.

Chapter 5: Changing perceptions

- 5.1 That the Victorian Government develops and implements a targeted multi-pronged campaign to reduce stigma associated with employment by people with mental illness through:
- Community education and awareness to promote positive perceptions of the employment of people with mental illness.
 - A program for employers with positive experiences to champion the employment of people with mental illness.
 - Providing practical guidance and support to employers in relation to recruiting and retaining employees with mental illness.

- 5.2 That the Victorian Government develops a targeted awareness campaign with relevant stakeholders to challenge perceptions of people with mental illness and improve responses in workplaces using multi-media and promotion tools in conjunction with other strategies.
- 5.3 That the Victorian Government works with relevant stakeholders to foster opportunities for employers to showcase positive experiences in recruiting and retaining workers with mental illness.
- 5.4 That the Victorian Government develops an internal strategy for improving recruitment and retention of people with mental illness and works with local councils to promote the employment of people with mental illness by local government.

Chapter 6: Providing diverse employment pathways

- 6.1 That, as part of a mental health employment strategy (see Recommendation 3.2), the Victorian Government works with relevant stakeholders to ensure a range of flexible employment options that enable people with varied experiences of mental illness to participate in the workforce.
- 6.2 That the Victorian Government increase awareness of the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) support services for employers and the assistance that the VEOHRC can provide to employers in making reasonable adjustments for workers with mental illness.
- 6.3 That the Victorian Government encourages the Commonwealth Government to undertake a review of the effectiveness of wage subsidies in fostering employment of people with mental illness, including:
 - An assessment of whether reducing the 15 hour requirement would enhance the effectiveness of subsidies to employers of people with mental illness.
- 6.4 That the Victorian Government works together with the Commonwealth Government to increase awareness of information services and supports available for workplaces that employ people with mental illness.
- 6.5 That the Victorian Government, in partnership with relevant stakeholders, develops a training strategy to up skill employers and supervisors in working with employees with mental illness and how to provide suitable workplace adjustments, including:
 - Incorporating mental health literacy training within human resources and management training curricula.
 - Engaging industry groups to promote the up-take of workplace mental health literacy training programs among members.
- 6.6 That the Victorian Government works with the Commonwealth to target small business as part of a campaign to increase employer awareness of information resources and supports available for workplaces that employ people with mental illness (see Recommendation 6.4).

- 6.7 That the Victorian Government undertakes a review of the social firm sector to determine the commercial viability of the sector and the success of social firms in transitioning people with mental illness into sustainable jobs in the open labour market.
- 6.8 That the Victorian Government undertakes an evaluation to determine the long term employment outcomes achieved by social procurement initiatives and the resulting social and economic benefits.
- 6.9 That the Victorian Government proactively supports social procurement through businesses employing workers with mental illness by:
 - Educating government departments and local councils about the social value of procuring goods and services from businesses that employ people with mental illness.
 - Increasing awareness of social firms and enterprises that can supply goods and services—for example through promotion of the Social Enterprise Finder to government departments and local councils.
 - Working with government departments and local councils to identify opportunities to procure goods and services from businesses employing people with mental illness.

Chapter 7: Fostering health and supportive workplaces

- 7.1 That through WorkSafe, the Victorian Government works with relevant stakeholders across Victoria to:
 - Increase awareness among employers on understanding and responding to work risks to mental health, including job stress and bullying.
 - Encourage organisations to review and update their policies and procedures relating to job stress and bullying.
- 7.2 That through WorkSafe, the Victorian Government works with relevant stakeholders to develop and implement a campaign that highlights:
 - The benefits of early intervention when employees display signs of becoming unwell or experience work-related mental health problems.
 - The productivity and health costs associated with work stress and other psychosocial hazards.
 - The value in workplaces providing counselling support and stress management training.
- 7.3 That through WorkSafe, the Victorian Government partners with relevant stakeholders such as *beyondblue* and Employee Assistance Program (EAP) providers to:
 - Develop industry-wide standards for responding to and supporting employees that present with mental health related issues.
 - Increase awareness among employers of effective services such as EAP that can assist employees and workplaces in managing the impacts of mental illness.

- 7.4 That the Victorian Government commissions a pilot study to evaluate the feasibility, and benefits of, including mental health problems into WorkSafe *Work health checks*.
- 7.5 That the Victorian Government works with relevant stakeholders to:
 - Evaluate existing return-to-work guidelines for employees who have taken leave due to mental illness to determine their effectiveness.
 - Increase awareness of effective return-to-work guidelines.

Chapter 8: Strengthening mental health services

- 8.1 That as part of the reforms to the mental health sector, the Victorian Government develops a professional development program for mental health practitioners to increase understanding of the importance of workforce participation in recovery for people with mental illness.
- 8.2 That as part of the Psychiatric Disability Rehabilitation and Support Services (PDRSS) reform framework, the Victorian Government establishes clear targets for achieving education and employment goals, including developing sector standards and linking funding to evidence-based care models.
- 8.3 That, as a priority, the Victorian Government increases the availability of evaluated programs that train peer workers to work in mental health services to provide support to people with mental illness in their recovery and workforce participation.
- 8.4 That through Community Mental Health Planning and Service Coordination Initiatives, the Victorian Government prioritises the development of more local partnerships between specialist mental health and employment support services that can effectively lead to inter-agency referrals, collaboration and knowledge transfer across sectors.
- 8.5 That the Victorian Government works with the Commonwealth Government to integrate vocational support within early intervention focused mental health services, including Early Psychosis Prevention and Intervention Centres (EPPIC) and headspace.
- 8.6 That in trialling the co-location of education and employment officers in area mental health services, the Victorian Government evaluates cost-barriers to integrating vocational support with clinical care, and strategies to address these challenges.

Introduction

On 10 February 2011, the Parliament of Victoria asked the Family and Community Development Committee to inquire into workforce participation by people with mental illness.

The importance of fostering workforce participation by people with mental illness has been increasingly recognised nationally and internationally. Employment provides people with an income to meet essential material needs, such as housing and food. It also links people with society. For many people, work provides a sense of meaning, purpose, and social connectedness.¹ Employment can also offer people routine and structure in their lives.²

Research reveals that people with mental illness often experience significant improvements when they secure a job.³ In view of the benefits of workforce participation, many people with mental illness have indicated their strong desire to work or continue working.

Yet people with mental illness have one of the lowest rates of participation in the workforce. The social and economic costs associated with low participation by people with mental illness in the workforce are considerable:

- When unable to participate in the workforce, people with mental illness are more exposed to social isolation, poverty and homelessness.
- The non-participation of people with mental illness cost the Victorian economy approximately \$2.7 billion in 2006.
- Absences related to mental illness were responsible for around 4.7 million lost working days in Victoria at an estimated cost of \$660 million in lost productivity in 2006.⁴

Despite evidence of these social and economic costs, employment does not feature strongly in mental health policy.⁵ Most mental health policy prioritises the provision of treatment services. Recovery services have traditionally focused on supporting people to develop skills to re-engage and live independently in the community, yet with minimal focus on workforce participation.

Reforms to mental health services are leading to an increased focus on the importance of workforce participation. Since 2006, governments in Victoria and at a national level have introduced a range of strategies to address some of the barriers to workforce participation by people with mental illness, such as the need for increased collaboration

1 Perkins, R., Farmer, P., & Litchfield, P. (2009) *Realising ambitions: Better employment support for people with a mental health condition—A review to government*. London, Disability and Work Division, United Kingdom Government Department for Work and Pensions, p.24.

2 *Submission 19, beyondblue*, p.4.

3 Organisation for Economic Co-operation and Development (OECD) (2012) *Sick on the job? Myths and realities about mental health and work*. OECD Publishing, p.203.

4 Boston Consulting Group (2006) *Improving mental health outcomes in Victoria: The next wave of reform—Report to the Government of Victoria*. Melbourne, Department of Premier and Cabinet, Victorian Government, p.12.

5 Organisation for Economic Co-operation and Development (OECD) (2012) *Sick on the job? Myths and realities about mental health and work*, p.203.

between mental health and employment services, and employment disincentives within eligibility criteria for welfare payments (see Chapter 3, Section 3.2).

This report makes recommendations to improve opportunities for people with mental illness to participate in the workforce.

Terminology

In considering workforce participation by people with mental illness, the Committee identified a need to clarify the terminology relating to the Terms of Reference, including:

- What is ‘workforce participation’ and how do people participate in the workforce.
- Who are ‘people with mental illness’.

What is workforce participation

Inquiry participants generally referred to workforce participants as those people with mental illness in employment. The Committee identified that definitions used as the basis for determining statistical rates of workforce participation tend to also include people who are unemployed but looking for work as participating in the workforce.

For the purposes of this Inquiry, the Committee considers workforce participation as involving employment of people with mental illness.

Following established international standards, the Australian Bureau of Statistics (ABS) defines employment as ‘work for one hour or more [per week], for pay, profit, commission or payment in kind in a job or business, or on a farm.’⁶ People who work one hour or more without pay are also considered employed by the ABS provided that they work in a family business or on a family farm.

In undertaking its Inquiry, the Committee has also considered the range of the jobs available to people with mental illness and the extent to which people with mental illness can pursue full-time and part-time employment.

Chapter 2 discusses the participation of people with mental illness in employment in more detail.

Who are people with mental illness

The Committee acknowledges that the phrase ‘people with mental illness’ refers to people who have diverse and varied experiences of a medical condition that can disrupt their thinking, feeling, mood, ability to relate to others and daily functioning.

In the evidence received, participants referred to people with mental illness in several ways, also including ‘people with mental health problems’ and ‘people with mental health issues.’

Definitions and understanding of mental illness can vary depending on the context in which they are used. They reflect a continuum from the broad definition of mental health care problems to narrower clinical definitions.

6 Australian Bureau of Statistics (2011) *Labour force, December 2011 (Catalogue. no. 6202.0)*. Canberra, Australian Bureau of Statistics, p.37.

The Department of Health and Ageing in the Commonwealth Government makes the following distinction:

- Mental health care problems are associated with mental illness that affects the ability of the individual to live independently in the community to their fullest potential. In this context, the impacts of mental illness on life circumstances are considered in addition to diagnosis.
- Within a clinical context, mental illness can be defined as a clinically recognisable set of symptoms (relating to mood, thought, or cognition) or behaviour that is associated with distress and interference with functions (that is, impairments leading to activity limitations or participation restrictions).

The experiences of people with mental illness are extremely diverse. Mental illness, and some types of mental illness, can have different degrees of effects on people's functioning. These effects can also vary at different times. This variability is generally known as the 'episodic' nature of mental illness.

This diversity in functioning and variability of effects of mental illness are important in understanding the intersections between workforce participation and mental illness (see Chapter 1, Section 1.1.1).

The Committee acknowledges that the concept of 'serious' or 'severe mental illness' has been used to describe some forms of mental illness. There is no agreed definition of these terms. Generally, however, they are used to refer to psychotic illnesses such as schizophrenia and bipolar disorder that are characterised by a loss of sense of reality, auditory or visual hallucinations, thought disorder and delusions. Other definitions, however, can be more inclusive, incorporating a wider range of mental disorders such as depression, anxiety and substance use disorders.

The terms 'high-prevalence mental illness' and 'low-prevalence mental illness' can also be used to distinguish different forms of mental illness. The term 'low-prevalence mental illness' is often used to refer to psychotic illnesses.⁷ However, sometimes the term is used more broadly to include other less common conditions such as eating disorders and severe personality disorder.⁸ 'High-prevalence mental illness' generally refers to depression, anxiety and related mental illness (such as post-traumatic stress disorder) that are more common across the population. Importantly, high-prevalence as well as low-prevalence mental illnesses can have severe impacts on people's functioning.

Inquiry process

The Committee undertook a comprehensive research and consultation process to inform its Inquiry.

In conducting the Inquiry, the Committee used a variety of processes to develop its understanding of the issues relating to workforce participation by people with mental illness.

7 See, for example, Frost, B., Carr, V., & Halpin, S. (2002) *Employment and psychosis: A bulletin of the low prevalence disorders study group*, report for the Department of Health and Ageing, Commonwealth of Australia.

8 See, for example, Department of Health and Ageing (2010) *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the national mental health strategy 1993-2008*. Canberra, Department of Health and Ageing, Commonwealth of Australia, p.16.

Meetings

The Committee met with key organisations to build its understanding of issues relating to people with mental illness and their workforce participation opportunities.

It received information related to current Victorian Government responses to workforce participation by people with mental illness.

It also met with the Parliament of Australia House of Representatives Standing Committee on Education and Employment. On 24 February 2011, the Standing Committee was asked by the Commonwealth Minister for Tertiary Education, Skills, Jobs and Workplace Relations to inquire into mental health and workforce participation. It released its final report in June 2012.⁹ The Committee considered it important to ensure a complementary approach between the inquiries and to focus its investigations on state-level responses to barriers and incentives to workforce participation experienced by people with mental illness.

Submission guide

The Committee prepared a Submission Guide to outline the scope and focus of its Inquiry and to assist those preparing written submissions. This was made available on the Committee's website and was also circulated to those who expressed an interest in submitting to the Inquiry.

The Submission Guide provided an overview of the major issues of relevance to the Committee's Inquiry and asked several questions on areas the Committee sought submissions.

Written submissions

A call for submissions was advertised in *The Age* and the *Herald Sun* on 15 October 2011. In addition, an advertisement was included in *The Weekly Times* seeking regional perspectives.

The Committee extended its invitation for submissions through an extensive database comprising a range of individuals and organisations, including service providers, advocacy bodies, community groups, industry and professional associations, unions, chambers of commerce, research institutes and academics.

The Committee received 44 written submissions from a diverse range of individuals and organisations. These included 11 submissions from individuals and 33 from organisations.

Submitters to this Inquiry included:

- area mental health services
- Psychiatric Disability Rehabilitation Support Services (PDRSS)
- community health services
- employment service providers

9 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*. Canberra, Parliament of the Commonwealth of Australia.

- community service organisations
- advocacy bodies
- employers
- peak and statutory bodies
- academic and research organisations.

The Committee also received submissions in confidence due to concerns the authors of these submissions had regarding the privacy of themselves and their families.

Public hearings

Public hearings were held in Melbourne between November 2011 and April 2012. The Committee heard from a variety of organisations, including those representing the interests of carers and people with mental illness, academics and research groups, industry groups, trade unions, community organisations, service providers and statutory bodies (such as WorkSafe Victoria, the Victorian Equal Opportunity and Human Rights Commission, and the Transport Accident Commission). The Committee also heard from the Department of Education and Early Childhood Development in the Victorian Government.

Regional hearings were held in Bendigo and Geelong in November 2011 to assist the Committee to gain a regional perspective.

In total, 51 witnesses representing 32 organisations appeared before the Committee.

Site visits

The Committee arranged site visits across Melbourne to assist its understanding of employment pathways for people with mental illness.

The Committee's site visits included Social Firms Australia in Fitzroy, Incito Maintenance and Clean Force Property Services in Northcote, and Prahran Mission in Prahran.

Requests for additional information

In June 2012, the Committee invited the Department of Business and Innovation to respond to a request for additional information. This was provided in late June 2012 and was of valuable assistance to the Committee in its deliberations.

It also sought information from the Department of Planning and Community Development relating to Victorian Government support of social enterprises and social procurement by Victorian Government departments and agencies. This response was received in July 2012.

In August 2012, the Committee contacted WorkSafe Victoria to request additional information related to the cost of occupational injury claims in Victoria and the process for responding to mental injury claims. This information was provided to the Committee in September 2012.

Report overview

The report is structured in eight chapters that address the key themes of the Terms of Reference for this Inquiry. Each of these chapters is briefly outlined below.

- Chapter 1** outlines the experiences of people with mental illness in gaining and retaining employment and their desire to work. It also considers key barriers to participation often experienced by people with mental illness.
- Chapter 2** considers rates of non-participation and unemployment among people with mental illness and the social and economic costs involved. It outlines the benefits of employment in recovery from mental illness, as well as the benefits to society, government and employers in fostering workforce participation by people with mental illness.
- Chapter 3** explains the policy context and key responsibilities of the Victorian and Commonwealth Governments in fostering workforce participation by people with mental illness. The chapter identifies the need for a mental health employment strategy for Victoria.
- Chapter 4** addresses the important role that education plays in fostering workforce participation by people with mental illness.
- Chapter 5** examines stigma and perceptions within workplaces that prevent the full participation of people with mental illness in employment, and strategies for addressing stigma and discrimination.
- Chapter 6** discusses the importance of providing diverse and flexible employment pathways to reflect people's varied experiences of mental illness.
- Chapter 7** considers the importance of fostering healthy and supportive workplaces in enabling people with mental illness to retain employment and in preventing early exits from work.
- Chapter 8** outlines the role of mental health services in supporting workforce participation by people with mental illness and the importance of enhancing linkages between mental health services and employment support services.

Chapter One: Experiences of people with mental illness

Findings

1. That people with mental illness are not an homogenous group. They have varied experiences of mental illness and treatment that lead to significant differences in people's level of participation and experiences of barriers to participation.
2. That people with mental illness often experience their first episode of illness between the ages of 16 and 25 years, which can disrupt their education and transition to employment.
3. That experiences of homelessness, social isolation, educational disadvantage and poor health linked with mental illness can compound barriers to workforce participation experienced by people with mental illness.
4. That the vast majority of people with mental illness value employment and are motivated to return to work.
5. That the impact of symptoms and the episodic nature of mental illness can affect levels of workforce participation. Key barriers to participation relate to community expectations, inflexibility within workplaces and difficulties in accessing support services.

This chapter considers the experiences of people with mental illness in participating in the workforce, including barriers experienced in gaining and retaining employment.

The Committee heard that people with mental illness are a diverse group and have different experiences of mental illness and its impact on their participation in the workforce. However, the vast majority of people with mental illness value employment and want to work.

Nevertheless, the Committee identified several barriers to gaining and retaining employment that often hinder workforce participation by people with mental illness.

These include the episodic nature of some mental illnesses and the impact that symptoms and medications can have on people's ability to function in their employment role. People with mental illness also experience indirect barriers to participation such as stigma and discrimination, inflexibility within workplaces, and issues accessing mental health and appropriate employment support services.

Inquiry participants also identified that factors associated with mental illness such as educational disadvantage, social disconnection and risk of homelessness can compound the difficulties experienced by people with mental illness in participating in the workforce.

1.1 People with mental illness in Victoria

In 2006, the Boston Consulting Group (BCG) identified that approximately 19 per cent of Victorians each year experience some degree of mental illness. It divided the experience of mental illness into three groups, based on the severity of the impact on the functioning of a person with mental illness. Figure 1.1 demonstrates the BCG approach.

Figure 1.1: Prevalence of mental illness by degrees of severity in Victoria

	Prevalence	Key Disorders	Typical Example
TIER 3	3% (Severe Disability)	<ul style="list-style-type: none"> • Psychotic Disorder • Bipolar Disorder • Severe Depression • Severe Anxiety • Severe Eating Disorder 	37 yr old male who episodically hears voices. He also has severe depression and has attempted suicide several times. He is unemployed, lives in public housing and is alienated from friends and family.
TIER 2	4% (Moderate Disability)	<ul style="list-style-type: none"> • Moderate Depression • Moderate Anxiety Disorder • Personality Disorder • Substance-Related Disorder • Eating Disorder • Adjustment Disorder 	21 yr old male with chaotic behaviour and complex problems. He is suicidal, uses drugs heavily, and experiences panic attacks. Gets into fights and was arrested for assault 4 weeks ago. He can not hold onto a job and is currently unemployed.
TIER 1	12% (Mild Disability)	<ul style="list-style-type: none"> • Mild Depressive Disorder • Mild Anxiety Disorder 	42 yr old female who feels down, tearful, irritable and has withdrawn from friends over the past 4-6 months. She takes many sick days because she feels down.

Source: Recreated from The Boston Consulting Group (2006) *Improving mental health outcomes in Victoria: The next wave of reform – Report to the Government of Victoria*, Melbourne, Department of Premier and Cabinet, Victorian Government, p.11.

Many more people may experience some degree of mental illness over the course of their life. For example, the Australian Bureau of Statistics (ABS) 2007 *National survey of mental health and wellbeing* (NSMHW) estimated that more than 40 per cent of Australians had experienced the symptoms of a higher-prevalence mental illness at some point in their lives.¹

1.1.1 Diverse experiences of mental illness

Throughout the Inquiry, participants emphasised that people with mental illness are not an homogenous group.² They have diverse experiences of mental illness and treatment. They have varying capacities for workforce participation. Some people's experience of mental illness may be relatively short-lived. Others experience 'more severely disabling or intransigent mental health problems.'³

In its submission, Open Minds commented that while one in five Australians will experience mental illness in any given year, 'that experience of mental illness will vary from individual to individual.'⁴ The submission went on to state that:

1 Australian Bureau of Statistics (2008) *National survey of mental health and wellbeing 2007: Summary of results* (Catalogue no. 4326.0). Canberra, Australian Bureau of Statistics, p.7.

2 Submission 36, Lantern, p.1.

3 Submission 28, VincentCare Victoria, p.8.

4 Submission 16, Open Minds, p.5.

For some, it might be a single episode with full recovery. For others, mental illness may be episodic in nature, coming and going through someone's life. It may even affect how a person functions over the course of a day. Similarly, treatment will vary and may involve medication, psychological counselling and lifestyle changes. Consequently every individual will also experience recovery differently.⁵

The Committee heard that many people are able to manage their symptoms well and maintain full participation in employment with no support. *Beyondblue* told the Committee that 'many people with depression and anxiety can participate in the workforce without any adjustments or support mechanisms.'⁶

For others, short periods of intensive support or time out from work can help in managing their illness and in sustaining their employment. In this context the Victorian Mental Health Carers Network (VMHCN) drew attention to the 'considerable publicity about high profile and high performing individuals who suffer from mental illness.'⁷ It explained that:

Their capacity may be reduced temporarily by their illness but they can often return successfully to their previous roles. The same is true of many not-so-prominent, ordinary members of our community, just like us and our children ... For example, many people well into tertiary education or into good careers are hit by mental illness, and given support at that time, may well recover and continue with a successful life.⁸

Box 1.1 Susan's story

Susan is a part-time employee at a large employer who has struggled with alcohol abuse following family breakdown for a number of years. Her mental health became more unstable as time went on without support and intervention, despite repeated attempts by her family to seek support. Both Susan and her family were concerned for her wellbeing, and particularly that she would be able to continue in her work.

The situation escalated to the point that Susan attempted suicide, and only at this time was she referred for assessment to a crisis assessment and treatment team (CATT), where she was later released with no follow up support.

The impact of this ordeal on Susan's employment meant that she became somewhat unreliable and her work was not of an appropriate standard. Nonetheless, following contact with Susan's family and meetings to address her work situation, Susan's employer sought to support her in her work situation to enable a recovery that has allowed Susan to continue working.

Susan was allowed to access her accrued leave (sick leave, annual leave, and long service leave) and the employer also allowed Susan to access unpaid leave when this paid leave ran out. As Susan began a recovery process, the employer worked with Susan to change her hours of work to enable medical appointments and lifestyle changes to facilitate recovery in her personal life.

Throughout the process, Susan's employer continued to treat her as a valuable staff member and managed the situation with sensitivity and confidentiality. As a result, Susan has fully recovered and maintained her important connection to the workplace. This has enabled her to purchase another home and get on with the rest of her life.

Source: Adapted from *Submission 8*, Geelong and Region Trades Hall and Labour Council, p.8.

⁵ *Submission 16*, Open Minds, p.5.

⁶ *Submission 19*, *beyondblue*, p.2.

⁷ *Transcript of evidence 5*, Victorian Mental Health Carers Network, 7 November 2011, p.4.

⁸ *Transcript of evidence 5*, Victorian Mental Health Carers Network, p.4.

A small percentage of people develop severe symptoms that require lengthy periods of hospitalisation and intensive treatment. The symptoms may be episodic and require repeat treatment over a long period. For people in these circumstances, the recovery period can be lengthy and it may be several months or even years before they can consider working again.

Finding suitable employment can be difficult due to interrupted educational and employment histories, and lengthy gaps in their résumé for the periods when they were unwell. As Mr Jeff Galvin, a peer educator working with Social Firms Australia (SoFA), told the Committee:

Your recovery time can be decades. Why I am behind the eight ball when I am looking for work is that when I apply for part-time employment in retail, which is what I used to do back before I fell unwell, and they look at my résumé and see my age—well, you do not usually tell your age, but you cannot hide it one way or another!—they say, ‘What’s wrong with him? He’s a 54-year-old male looking for part-time work in retail in a bookstore or a record store.’ You just get written off. You do not even get to the interview stage. I would like to think that if I could get to the interview stage, I would have a chance; but no.⁹

Finally, as the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) observed, some people ‘may not be able to participate in the workforce at all, due to the severity and impact of their illness.’¹⁰

FINDING 1

That people with mental illness are not an homogenous group. They have varied experiences of mental illness and treatment that lead to significant differences in people’s level of participation and experiences of barriers to participation.

1.1.2 Other experiences associated with mental illness

The Committee acknowledges that the experiences or characteristics of people with mental illness cannot be easily generalised. Nevertheless, there are certain experiences that are more common among people with mental illness as a group than the general population that can compound the potential negative impacts of mental illness on employment. For example, mental illness can exacerbate or lead to experiences of:

- lower levels of educational attainment
- social disconnection
- increased risk of homelessness
- poorer physical health.

Almost all people with mental illness are vulnerable to these risk factors. They are especially pronounced among those living with psychotic illness and other mental illnesses, such as severe depression. Several of these factors, including social disconnection and homelessness, also negatively impact mental health and hinder recovery further compounding the difficulties that people with mental illness can experience in finding and maintaining employment. For example, in a report on the

⁹ *Transcript of evidence 15*, Social Firms Australia, 28 February 2012, pp.7-8.

¹⁰ *Submission 41*, Victorian Equal Opportunity and Human Rights Commission, p.4.

importance of social inclusion to mental health, the Mental Health Coordinating Council (MHCC) stated that ‘isolation during illness and recovery adds to the burden of the illness and directly impedes the healing process.’¹¹

Educational disadvantage

The onset of mental illness in people’s lives is often before the age of 25 years, ‘with the first episode of serious mental illness most likely to occur in the period from 16–25 years.’¹² It is often associated with disruptions to education, and can result in people leaving education early. As a result, levels of educational attainment are often lower among people with mental illness than among people with no mental illness.

This is particularly evident for people with psychotic illness. For example, just under one-third of people with psychosis who took part in the Commonwealth Government’s *People living with psychotic illness 2010* survey had completed year 12 or its equivalent compared with more than half of the general population.¹³

As Chapter 4 discusses in greater detail, people’s employment prospects are closely associated with their level of educational attainment. Orygen Youth Health (OYH) explained in its submission that:

Data from both the general community and in the population of people with mental illness shows that completing high school is a strong predictor of future vocational success. In addition, each additional post secondary education or training qualification is associated with higher earnings and lower unemployment.¹⁴

FINDING 2

That people with mental illness often experience their first episode of illness between the ages of 16 and 25 years, which can disrupt their education and transition to employment.

Social disconnection

I unconsciously withdrew at 19, ‘took myself out of the game’ in order to lessen my anxiety ... Withdrawing however only intensified my anxiety, gave me new problems ... Being connected, staying connected, is better than marginalisation, much better.¹⁵

Social disconnectedness can erode sources of belief and motivation that are important to successful job seeking such as self-confidence and self-esteem.

11 Merton, R. & Bateman, J. (2007) *Social inclusion: Its importance to mental health*. Rozelle, NSW, Mental Health Coordinating Council, p.10.

12 Department of Human Services (2009) *Because mental health matters: Victorian mental health reform strategy 2009-2019*. Melbourne, Mental Health and Drugs Division, Department of Human Services, State of Victoria, p.48.

13 Morgan, A.J., Wattereus, A., Jablensky, A. et al. (2011) *People living with psychotic illness 2010*, report for the Department of Health and Ageing, Commonwealth of Australia, p.3.

14 *Submission 18*, Orygen Youth Health, p.7.

15 *Submission 21*, Dowe, P., p.4.

Studies consistently show the importance of participation in social networks for mental, as well as general, health. The Victorian Health Promotion Foundation (VicHealth) has explained that:

Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued. This has a powerful protective effect on health.¹⁶

VicHealth highlighted that, in the *Victorian population health survey 2002*, people with fewer social networks were more likely to experience some level of psychological distress. It also noted that studies suggest that young people experiencing social disconnectedness 'are between two and three times more likely to experience depressive symptoms' than peers with a greater number of supportive relationships.¹⁷

Having mental illness can make social participation more difficult. According to the Mental Health Coordination Council of New South Wales, people with mental illness are more likely to have smaller social networks (5–13 social contacts on average) than the general population (25 social contacts on average). Moreover, for people with mental illness, 'their network tends to decrease in size as the duration of their illness increases.'¹⁸

Homelessness

The results of the *People living with psychotic illness 2010* survey found that more than 10 per cent of those living with psychosis had experienced a period of homelessness in the twelve months before the survey.¹⁹

The association between mental illness and homelessness appears to run in both directions. For example, the *Victorian mental health reform strategy* reports that at least 30 per cent of people who are homeless have identified mental health problems, with over half reporting having developed a mental health problem since becoming homeless.²⁰ In the ABS 2007 NSMHW, the prevalence of 12-month mental illness was over two and a half times higher among people who had been homeless at some point in their life than among the general population.²¹

Several Inquiry participants pointed out that addressing homelessness for people with mental illness is critical to enabling them to participate in employment. VincentCare, for example, stated that 'workforce participation solutions need to be integrated into comprehensive and long term supports which aim to assist people to exit and stay out of homelessness.'²²

16 Victorian Health Promotion Foundation (VicHealth) (2005) *Research summary 2: Social inclusion as a determinant of mental health and wellbeing*. Melbourne, VicHealth, p.3.

17 Victorian Health Promotion Foundation (VicHealth) (2005) *Research summary 2: Social inclusion as a determinant of mental health and wellbeing*, pp.3-4.

18 Merton & Bateman (2007) *Social inclusion: Its importance to mental health*, p.9.

19 Morgan, Wattereus, Jablensky et al. (2011) *People living with psychotic illness 2010*, p.9.

20 Department of Human Services (2009) *Because mental health matters: Victorian mental health reform strategy 2009-2019*, p.31.

21 Slade, T., Johnston, A., Teesson, M. et al. (2009) *The mental health of Australians 2: Report on the 2007 National survey of mental health and wellbeing*, report for the Department of Health and Ageing, Commonwealth of Australia, p.8.

22 Submission 28, VincentCare Victoria, p.8. See also Submission 14, The Royal Australian and New Zealand College of Psychiatrists (RANZP)—Victorian Branch, p.5.

Poor physical health

Just turning 55 soon, the sunset of my years I suppose ... [O]ther more 'normal' people are at my age, thinking of retirement, I'm wondering if I'll ever manage to get a foot in the door of employment for another 10 years or so. I have knee injuries and pain, as well as my psychiatric shortcomings.²³

A lot of people who live with mental illness have side-effects with medication where weight gain is enormous. There is stigma out there for people who carry weight. Some studies have been done in interviews, and your chance of getting a job if you carry weight is less ... Sometimes there are dual barriers: it is not just your mental illness, it is the circumstantial stuff around it.²⁴

The Victorian branch of the Australian Medical Association (AMA) indicated to the Committee that poor physical health 'can arise as a consequence of the effects of mental illness on lifestyle as well as prescribed medication and can negatively impact on a person's ability to stay in employment.'²⁵ However, as the *Victorian mental health reform strategy* has observed, poverty may also be a contributing factor to the poorer physical health of people with mental illness compared with the broader population.²⁶

FINDING 3

That experiences of homelessness, social isolation, educational disadvantage and poor health linked with mental illness can compound barriers to workforce participation experienced by people with mental illness.

1.2 People with mental illness want to work

Participants identified that workforce participation is a key issue for people with mental illness. VincentCare emphasised that 'paid work is an important catalyst for social inclusion and overall wellbeing' and is important in fostering personal fulfilment, social connection and material gain.²⁷ It explained that:

Part of the burden of disability of mental illness occurs because *not working* excludes people from the social and economic benefits of employment which many of us take for granted.²⁸

In its submission, *beyondblue* included comments from people with mental illness who identified that:

One of the biggest parts of recovery is getting work again. That's how you can pay for stuff, that's going to help you have social inclusion. You can pay to have quality of lifestyle.²⁹

Mission Australia highlighted that employment impacts positively on many areas of the lives of people with mental illness, including 'income, overall physical and mental health, sense of self and wellbeing, connectedness to broader community and overall

23 Submission 4, Name withheld, p.1.

24 Transcript of evidence 15, Social Firms Australia, p.8.

25 Submission 34, Australian Medical Association (AMA) Victoria, p.2.

26 Department of Human Services (2009) *Because mental health matters: Victorian mental health reform strategy 2009-2019*, p.40.

27 Submission 28, VincentCare Victoria, p.6.

28 Submission 28, VincentCare Victoria, p.4.

29 Comment from a person with mental illness quoted in Submission 19, *beyondblue*, p.4.

social inclusion levels.³⁰ It went on to explain that employment is valuable for people with mental illness because it:

- reduces stigma by providing access to a socially-valued role;
- strengthens both self-efficacy and self-esteem;
- increases opportunities for receiving positive regard from others;
- increases opportunities for social inclusion; and
- provides time structure and a reason to stay well.³¹

The Committee heard that the vast majority of people with mental illness want to work and identify participation in employment as important to their recovery. As Dr Geoff Waghorn from the Queensland Centre for Mental Health Research told the Committee, ‘systemic exclusion from the labour force is not what people with psychiatric disabilities want.’³² He cited analysis from the most recent national survey of people living with psychotic illness which shows that more than 68 per cent of community residents with psychosis want to work in competitive employment.

This study was also cited in evidence by Professor Eoin Killackey from OYH. He told the Committee that:

There are a number of studies which have asked people in an open ended way, ‘What do you want to do?’, and more people nominate getting work than nominate getting their health stable. It is quite a fascinating thing when you think about it. In some ways, though, it is not surprising that people just want to be normally participating in the community and have the same abilities to do things that other people do. In a recent SHIP study—the Survey of High Impact Psychosis [*People living with psychotic illness 2010*—in a report [that] was released towards the end of last year again the top three issues that were nominated by the 1,700 people I think that were in that study were financial stability, employment and social inclusion. Those three things I think are actually the one thing, really. I think employment is the way back to both financial stability and social inclusion.³³

In its submission, SANE similarly drew the Committee’s attention to the results of a survey it had carried out of more than 280 people living with mental illness. More than 80 per cent of those surveyed ‘were either in employment of some form, or wanted work’ confirming ‘how highly people affected by mental illness value employment, and are motivated to return to work.’³⁴

FINDING 4

That the vast majority of people with mental illness value employment and are motivated to return to work

30 Submission 29, Mission Australia, p.4.

31 Submission 29, Mission Australia, p.4.

32 Submission 42, Dr Geoff Waghorn—Queensland Centre for Mental Health Research, p.10.

33 Transcript of evidence 13, Orygen Youth Health, 28 February 2012, p.2.

34 Submission 7, SANE, p.3. See also SANE (2006) *Research bulletin 3: Employment and mental illness*. Melbourne, SANE, p.1.

1.3 Barriers to workforce participation

The Committee identified that people with mental illness face considerable obstacles to gaining and retaining employment that result either directly or indirectly from their mental illness.

Direct barriers to participation experienced by people with mental illness relate to the way in which the positive and negative symptoms of mental illness affect people's functioning and their capacity to work. For example, some forms of psychotic illness affect cognitive functioning and stamina, influencing the types of roles people can be suited to.

People with mental illness can also experience indirect barriers to participation related to community expectations and inflexibility within workplaces. For example, the Committee heard that those involved in caring for people with mental illness can sometimes have expectations about employment that differ from the wishes of people with mental illness.³⁵

The Committee recognises that families and carers play a key role in supporting those they care for, as highlighted in the Carers Recognition Bill 2012 (Vic). The Bill seeks to recognise, promote and value the role of people in care relationships, recognising that care relationships bring benefits to the people in the care relationship and to the community. In seeking to recognise the value of carers, section 7(e) of the Bill states that a carer should:

Have the effect of his or her role as carer on his or her participation in employment and education recognised and considered in decision making.³⁶

As several Inquiry participants highlighted, many carers themselves experience difficulties participating in the workforce because of the impact that caring has on their lives.³⁷ Some participants suggested that 'it is crucial to include carers as part of the team which is assisting a consumer to return to or remain in employment.'³⁸ At the same time, the Committee is aware that people with mental illness may not always want to involve carers in decisions related to their workforce participation.

As discussed in Section 1.1.2 some people with mental illness are exposed to other issues that can affect their engagement in the workforce. These include homelessness, poor physical health, and disruption to education.

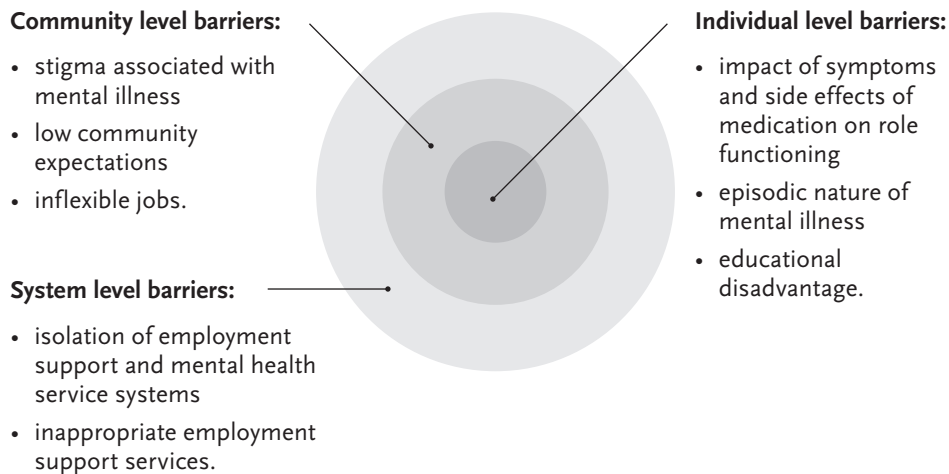
The Committee found that the direct and indirect barriers to participation experienced by people with mental illness can be broadly classified into three levels according to the level at which intervention is needed to address them: individual, community and system level barriers.

³⁵ *Transcript of evidence 25*, Mental Illness Fellowship of Victoria, 7 March 2012, p.5.

³⁶ Carers Recognition Bill 2012 (Vic) s 7(e).

³⁷ *Submission 26*, Victorian Mental Health Carers Network, p.2, p.9. See also *Submission 19*, *beyondblue*, p.4.

³⁸ *Submission 26*, Victorian Mental Health Carers Network, p.11.

Figure 1.2: Barriers to workforce participation experienced by people with mental illness

Source: Compiled by Family and Community Development Committee.

FINDING 5

That the impact of symptoms and the episodic nature of mental illness can affect levels of workforce participation. Key barriers to participation relate to community expectations, inflexibility within workplaces and difficulties in accessing support services.

1.3.1 Impact of mental illness on the individual

The Committee identified that for some people with mental illness, the difficulties experienced in participating in employment stem directly from the symptoms of their illness or the episodic nature of mental illness.

Impact of symptoms

Mental illness affects people's cognitive, perceptual, affective and interpersonal abilities. This can impact on their capacity to engage in work. Depression, for example, can lead to loss of energy, motivation, and self-confidence. Schizophrenia can be associated with 'fatigue and impaired attention, concentration and poor memory.'³⁹ These effects of mental illness can limit the number of consecutive hours that people can work.

For some people, the 'high burden of side effects' associated with antipsychotic and mood-stabilising medications is a barrier to working.⁴⁰ In her submission, Ms Jennifer Marriner explained that some medications taken for mental illness have side effects that 'may affect the types of jobs someone can undertake.'⁴¹ For example:

Some medications have a sedative effect, therefore driving machinery or working with machinery would not be suitable in these cases.⁴²

39 Lelliott, P., Tulloch, S., Harvey, S. et al. (2008) *Mental health and work: A report for the cross government health, work and well-being program*, Royal College of Psychiatrists, p.11.

40 Harris, A. & Anderson, J. (2009) 'The effects of mental illness on young people's participation in the workforce'. *Journal of Occupational Safety*, Vol. 25, No. 1, pp.19-27, p.21.

41 Submission 3, Marriner, J., p.4.

42 Submission 3, Marriner, p.4.

Researchers have indicated that the sedative effects of medication can also make it more difficult to work standard hours, such as 9:00am till 5:00pm.⁴³ This issue was also raised by people with mental illness during the Committee's site visits to social enterprises (see Chapter 6, Section 6.2.2).

Waghorn and Lloyd also note that clinical symptoms of mental illness may also affect people's participation in employment as a consequence of impacts on 'social skills development'.⁴⁴

Episodic nature of mental illness

The fluctuating or episodic nature of mental illness can present barriers to workforce participation for people with mental illness, particularly in relation to maintaining employment.

For people in employment, the episodic nature of mental illness can mean that there are periods when intensive support or scaling down work demands are necessary.

People with mental illness can experience long periods of stability with little or no need for additional support.

The stigma associated with mental illness means that people often do not disclose their illness to their employer and co-workers (see Chapter 5, Section 5.1.3). Consequently, when severe symptoms present within the workplace, managers and co-workers can mistake these for performance issues. In these situations, support would potentially assist the person to maintain their position.

Chapter 6 discusses strategies for supporting people's needs for flexibility in employment to manage the episodic nature of mental illness.

1.3.2 Community level barriers

The Committee heard that many barriers experienced by people with mental illness in obtaining employment have little or no relation to their mental illness and how it affects their functioning and capacity to work.

Other barriers can be caused by the way in which the community—employers, family members, friends, healthcare professionals—views people with mental illness, and particularly their capacity to cope with the demands of work.

Stigma and low expectations

Stigma refers to the negative and demeaning attitudes, as well as misconceptions, that people can hold in relation to mental illness. OYH told the Committee that:

There are two key areas of stigma about mental illness that need to be addressed to help achieve better employment outcomes for Victorians with mental illnesses.

The first is what might be called societal stigma. This is the general stigma about mental illness that exists in the community. It manifests in the way that all stakeholders interact with someone who they know to have mental illness ...

43 Harris & Anderson (2009) 'The effects of mental illness on young people's participation in the workforce', p.21.

44 Waghorn, G. & Lloyd, C. (2005) 'The employment of people with mental illness'. *Australian e-Journal for the Advancement of Mental Health*, Vol. 4, No. 2 (supplement), pp.1-43, p.21.

Self-stigma is the stigma that people with mental illness direct at themselves. It results as a function of their having grown up in the same society, absorbing the same messages about mental illness as the rest of the population.⁴⁵

Participants informed the Committee that the stigma associated with mental illness is one of the most pervasive barriers to workforce participation for people with mental illness.⁴⁶

The Committee heard that many employers overlook people with mental illness in recruitment because ‘once employers know that the applicant has mental health issues, the perception is that they will be unreliable employees at best ... there is a perception among employers that they are taking on a liability.’⁴⁷

People with mental illness can therefore be reluctant to disclose their mental illness to potential employers. This tendency to hide mental illness to avoid stigma can create stress and anxiety for people with mental illness when returning to employment. It can also prevent people from seeking assistance in the workplace during periods when they experience a decline in their mental health.

When I was suffering, I was ashamed. I didn’t let people know what I was going through. In the workplace, everybody thinks ‘oh, everybody’s competent, should be in charge’. You think, ‘how can I tell somebody I’m anxious?’ I think as part of the introduction to the workplace, there should be a session that says ‘if you are feeling depressed or anxious, you should talk to somebody’.⁴⁸

Participants informed the Committee that well-meaning family members and carers may discourage people with mental illness from seeking employment because of concerns that the stress of work may lead to a worsening in mental health. As Prahran Mission identified:

The stigma of mental illness in terms of capacity to become employed is also carried by mental health workers themselves. Some clinical workers believe that people with a mental illness cannot and will never be employed and therefore will not work towards this goal with participants.⁴⁹

45 *Submission 18*, Orygen Youth Health, pp.4-5.

46 *Submission 40*, Mental Health Legal Centre, pp.4-5.

47 *Transcript of evidence 7*, Youth Support and Advocacy Service (YSAS), 18 November 2011, p.2.

48 Example reported in *Submission 19, beyondblue*, p.5.

49 *Submission 15*, Prahran Mission UnitingCare, p.3.

Box 1.2 Sophie's story

Sophie is a senior level personal assistant in a large corporation, who suffers from depression. After 10 months in her employment, her employer approached her and said that although there were no problems with her performance, 'it wasn't working out' so the company was prepared to offer her a separation package in exchange for her resignation. Sophie believes that her disclosure to her employer of her depression was a significant factor in his decision to terminate her employment.

She wished to stay in her job, however she realised that it would be untenable. She was made aware that the actions of her employer potentially contravened equal opportunity and fair work laws. However, Sophie elected not to pursue legal action against her employer.

She had really wanted to do so, as she was extremely upset that she had lost her job and felt that she had been unfairly discriminated against. But she was worried that she would be unable to withstand the pressures of taking legal action against a large corporation and did not want to be the subject of what she expected would be a rigorous and aggressive defence. She was also very concerned that the company would draw out the process and cause her to incur significant legal costs.

Source: Adapted from *Submission 44*, JobWatch, pp.19-20.

Inflexible employers

Many people with mental illness can sustain successful careers without the need for workplace adjustments or support. However, as SANE identified in its submission, others 'may have times when they need flexibility, such as being able to work part-time, work from home at times, or have workplace adjustments made.'⁵⁰

The Committee heard that some employers and managers are unwilling to make such accommodations. This can make it challenging for people with mental illness to sustain their employment. The Acting Commissioner for the VEOHRC, Ms Karen Toohey, told the Committee that 'there is a perception that flexible work arrangements are more expensive, but in fact they are not.'⁵¹

Box 1.3 P's story

P, a 30 year old male has been working in a factory for four years and has struggled with mental illness. For most of his time in this workplace he has had a supervisor who understood the complexities of mental illness because he has a child with a mental illness, and therefore was very supportive towards P. The supervisor allowed P to attend local services for treatment and P has been undergoing a variation to his medication which has impacted on his ability to function. Recently, the supervisor retired and a new supervisor has been appointed.

The new supervisor has taken the view that P needs to 'pull himself together' and can make his appointments with services and doctors in his own time, not company time. P has already used up all of his sick leave and annual leave and is expected to turn up for work every day regardless.

The increased stress put on P has caused more problems for him and he is now on a downward spiral and struggling to attend work or medical treatment. The most likely outcome of this scenario is that P will be sacked.

Source: Extracted from *Submission 8*, Geelong and Region Trades Hall and Labour Council, p.3.

50 *Submission 7*, SANE, p.6. See also SANE (2011) *Research bulletin 14: Working life and mental illness*. Melbourne, SANE, p.2.

51 *Transcript of evidence 10*, Victorian Equal Opportunity and Human Rights Commission, 21 November 2011, p.6.

1.3.3 System level barriers

The Committee found that disconnections across service systems and inappropriate employment support services can be barriers to workforce participation for people with mental illness.

Service silos

Inquiry participants highlighted that the lack of coordination between employment support and clinical treatment services is a key barrier to participation.⁵²

Navigating the different service systems can be extremely complex and time consuming, particularly if people with mental illness also use other government-funded services. Chapter 3 discusses the roles and responsibilities of different levels of government across service systems. OYH highlighted that:

People with mental illness, who are clients of a mental health service and who wish to seek employment, automatically have to negotiate two bureaucratic administrations—the mental health and the employment systems. The difficulty of negotiation is not limited to actually understanding the requirements of each, but may be as simple as overcoming the geographic differences between agencies—i.e. just figuring out where the employment office is and how to get there.⁵³

OYH also pointed out that the structural separation of employment and clinical services can lead to delays in the provision of job search assistance.⁵⁴ Such delays do not match the need to support people with mental illness to look for work as soon as they are motivated to do so, which participants identified as critical to successful employment support outcomes.⁵⁵ In Chapter 8, the Committee considers a number of approaches to increasing coordination between employment support and clinical treatment services, including the co-location of services.

Inappropriate employment support services

Participants expressed concern about the capacity of the existing Commonwealth-funded employment support services to respond effectively to the employment needs of job seekers with mental illness. This issue was also frequently raised in evidence to the 2012 House of Representatives Standing Committee on Education and Employment Inquiry into mental health and workforce participation (the ‘Federal Inquiry’).

The Federal Inquiry recommended a series of reforms to increase the effectiveness of employment services in supporting job seekers with mental illness, including a recommendation that:

Any future Disability Employment Services tender process require prospective disability employment services providers to provide evidence of expertise in working with people with mental illnesses.⁵⁶

52 See for example *Submission 19, beyondblue*, p.6; *Submission 18*, Orygen Youth Health, pp.3-4; *Submission 41*, Victorian Equal Opportunity and Human Rights Commission, pp.11-12; *Submission 26*, Victorian Mental Health Carers Network, p.7.

53 *Submission 18*, Orygen Youth Health, p.3.

54 *Submission 18*, Orygen Youth Health, p.4.

55 *Transcript of evidence 25*, Mental Illness Fellowship of Victoria, p.3.

56 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*. Canberra, Parliament of the Commonwealth of Australia, p.197.

The Committee also heard that there is a need for increased mental health literacy among employment support service providers. Participants indicated that job seekers with mental illness may be placed into unsuitable and unsustainable jobs by employment support providers who do not understand the complex needs of people. For example, Pathways and Barwon Health told the Committee that ‘job seekers with a mental health illness are frequently encouraged to return to a trade or industry in which they originally became unwell.’⁵⁷

Inquiry participants also criticised the job capacity assessment process used to allocate job seekers into funding streams that determine the level of job search assistance they can be provided with.⁵⁸ Problems with the assessment process were considered in detail in the Federal Inquiry, which recommended that:

The Commonwealth Government work with employment service providers to streamline assessment processes for job seekers with a mental illness and ensure that the assessment criteria for and requirements of job seekers with a mental illness are compatible and consistent across the services.⁵⁹

Box 1.4 James’ story

James holds three degrees from the University of Newcastle: a Bachelor of Economics, a Bachelor of Commerce and a Bachelor of Mathematics. Throughout these degrees he has maintained a distinction average, been placed on the Dean’s Commendation List twice and awarded a University prize. James also lives with depression and social anxiety disorder.

Following the completion of each degree James has been keen to use his acquired skills and knowledge in employment which is relevant to his expertise. However, since finishing his third degree in 2006, James has been placed in [a] range of part-time positions through Disability Employment Service providers as a store assistant and cleaner. Whilst working in these positions, which saw him significantly underemployed and his skills underutilised, James experienced frequent periods of poor mental health and hospitalisation ...

In 2011, James successfully secured an Internship with the Department of Families, Housing, Community Services and Indigenous Affairs through the Australian Network on Disability *Stepping into...* program. He gained experience as a program officer, working with datasets and statistics. Following the internship, James has accepted a full-time [graduate position] with the Department. Since being in a role which aligns with his skills and capabilities, James’ mental health and general outlook on life has improved markedly. He is paying back his HECS loan and has purchased a new car.

Source: Extracted from *Submission 35*, Australian Network on Disability, p.2.

The barriers to workforce participation experienced by people with mental illness, and described in the sections above, are discussed more extensively throughout the remainder of this report. Chapter 2 considers the impact of these barriers on rates of workforce participation and unemployment among people with mental illness and the social and economic costs involved.

⁵⁷ *Submission 23*, Pathways Rehabilitation and Support Services & Barwon Health, p.8. See also *Transcript of evidence 5*, Victorian Mental Health Carers Network, p.5.

⁵⁸ *Submission 15*, Prahran Mission UnitingCare, pp.4-5.

⁵⁹ House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.180.

Chapter Two: The case for increasing workforce participation

Findings

1. That employment can have a very positive influence on the recovery of a person with mental illness. Having a job is often just as important to recovery as secure housing and is important for social inclusion.
2. That recent Victorian data related to labour force participation among people with mental illness is limited.
3. That people with mental illness have a much lower workforce participation rate than those with no mental illness.
4. That people with mental illness who are in employment are less likely to work full-time. However, it is unclear whether this is because many people with mental illness prefer to work part-time or whether it reflects high under-employment among workers with mental illness.
5. That statistics may under-report the extent to which people with mental illness who are able and looking for work are excluded from employment.
6. That estimates of the labour force participation and unemployment rates among people with mental illness vary across surveys due to differences in how surveys define people with mental illness.
7. That fostering workforce participation by people with mental illness benefits individuals, families and carers through reducing social exclusion, poverty and homelessness, and enabling carers to participate more fully in employment.
8. That increasing workforce participation among people with mental illness can reduce government expenditure on health and welfare services and increase economic output over time.
9. That supporting people with mental illness in the workplace to remain well and participate to their full potential can benefit employers through retention of skills and reducing productivity loss by reducing unscheduled leave.

This chapter considers the benefits for individuals, employers and society more broadly in fostering workforce participation by people with mental illness.

The Committee identified that participation in employment positively influences health and wellbeing and is an important element in recovery from mental illness. It found that rates of unemployment and non-participation in the workforce are significantly higher among people with mental illness compared with people with no mental illness. The Committee identified however that estimates can vary significantly across surveys and that recent Victorian data on workforce participation by people with mental illness is limited.

The Committee found that high rates of unemployment and non-participation among people with mental illness impose substantial costs on people with mental illness, their families, business and government. Significant costs also arise from untreated mental illness among workers, including the costs of lost working days due to mental health related sickness absences.

Based on its findings, the Committee determined that there is a strong social and economic basis for fostering workforce participation by people with mental illness.

Employment-related costs alone account for more than half of the total economic costs associated with mental illness.¹ Social costs resulting from low workforce participation by people with mental illness include poverty, social isolation and homelessness.

Many of these costs could be avoided through creating pathways into employment for people with mental illness and supporting those in the workforce to stay well and maintain their employment.

2.1 The positive influence of workforce participation on mental health

Many Inquiry participants highlighted the significant benefits of participating in the workforce for people with mental illness. Inquiry participants told the Committee that people with mental illness value employment because it contributes to social inclusion and recovery in addition to improved financial security.² *Beyondblue* highlighted in its submission that:

An income provides greater access to resources, such as housing and food, which is essential for social inclusion and meaningful participation in the community. Employment also provides individuals with a defined social role, identity and purpose; access to social support and social networks; and a routine and structure.³

There is a strong body of evidence that shows the positive influence of employment on mental health. In its report, *Let's get to work*, the Mental Health Council of Australia (MHCA) noted that while work can contribute to stress 'it is more beneficial for a person's mental health than unemployment.'⁴

1 Boston Consulting Group (2006) *Improving mental health outcomes in Victoria: The next wave of reform—Report to the Government of Victoria*. Melbourne, Department of Premier and Cabinet, Victorian Government, pp.12-12.

2 Submission 7, SANE, p.3. See also SANE (2006) *Research bulletin 3: Employment and mental illness*. Melbourne, SANE, p.1.

3 Submission 19, *beyondblue*, p.4.

4 Mental Health Council of Australia (2007) *Let's get to work: A national mental health employment strategy for Australia*. Mental Health Council of Australia, p.17.

Unemployment is associated with diminished self-esteem, reduced social contact and poverty.⁵ People with mental illness can be particularly sensitive to these negative effects of unemployment. This is highlighted in a report on mental health and work produced by the Royal College of Psychiatrists.⁶ By contrast, the MHCA states that employment positively influences mental health through providing 'opportunities to regain a routine, achieve a better standard of living and interact with people outside of the mental health system.'⁷

A report prepared for the World Health Organization (WHO) and International Labour Organisation (ILO) identifies five key aspects of employment related to positive mental health. These are:

- time structure (an absence of time structure can be a major psychological burden)
- social contact
- collective effort and purpose (employment offers a social context outside the family)
- social identity (employment is an important element in defining oneself)
- regular activity (organising one's daily life).⁸

This is further supported by the findings of a 2008 literature review on the employment of people with mental illness prepared for the Commonwealth Department of Education, Employment and Workplace Relations (DEEWR). The review cites several international studies showing that participation in employment results in significant symptom improvement and fewer hospitalisations among people with mental illness.⁹

The Chair of the former Victorian Mental Health Reform Council (VMHRC), Mr Terry Laidler, told the Committee that providing pathways into meaningful occupation can make a critical difference in whether people recover from mental illness. He suggested that fostering workforce participation is equally as important to recovery as housing and social inclusion.¹⁰

This view was supported by the Co-Convenor of Open Minds, Ms Maria Katsonis. Open Minds is a network for Victorian public servants with mental illness and public servants who care for people with mental illness. Ms Katsonis explained:

What I would suggest about employment in the workplace is that it plays a key role in recovery from mental illness. During mental illness you lose the attributes of self-worth and confidence, and work plays a fundamental role in assisting you regain those by

5 Mental Health Council of Australia (2007) *Let's get to work: A national mental health employment strategy for Australia*, p.17.

6 Lelliott, P., Tulloch, S., Harvey, S. et al. (2008) *Mental health and work: A report for the cross government health, work and well-being program*, Royal College of Psychiatrists, p.17.

7 Mental Health Council of Australia (2007) *Let's get to work: A national mental health employment strategy for Australia*, p.17.

8 Harnois, G. & Gabriel, P. (2000) *Mental health and work: Impact, issues and good practices*. Geneva, World Health Organisation and International Labour Organisation, p.5.

9 Department of Education, Employment and Workplace Relations (2008) *Employment assistance for people with mental illness: Literature review*. Canberra, Department of Education, Employment and Workplace Relations, Commonwealth of Australia, p.13. These studies are also reviewed in Frost, B., Carr, V., & Halpin, S. (2002) *Employment and psychosis: A bulletin of the low prevalence disorders study group*, report for the Department of Health and Ageing, Commonwealth of Australia, p.2.

10 *Transcript of evidence 4*, Victorian Mental Health Reform Council, 7 November 2011, p.3.

providing a sense of purpose and a sense of meaning. It is also important in relation to dealing with and establishing social networks—that is, that feeling of social inclusion.¹¹

As outlined in Chapter 3, supporting people with mental illness to return to work as part of their recovery is an emerging focus of mental health services and mental health reform in Australia, particularly Victoria. During the Inquiry, the Committee identified opportunities for specialist mental health services in Victoria to increase their focus on supporting the vocational rehabilitation of people who use their services. These opportunities, and the broader role of mental health services in supporting workforce participation by people with mental illness, are discussed in Chapter 8.

FINDING 1

That employment can have a very positive influence on the recovery of a person with mental illness. Having a job is often just as important to recovery as secure housing and is important for social inclusion.

2.2 Understanding workforce participation

The Committee identified that the term workforce participation is often used in a way that includes everyone who is working or looking for work. This includes people who are employed and unemployed.¹²

For the purposes of this Inquiry, the Committee considered it important to adopt a definition of workforce participation that focuses on the employment of people with mental illness. As described in the Introduction, the Australian Bureau of Statistics (ABS) defines employment as:

Work for one hour or more [per week], for pay, profit, commission or payment in kind in a job or business, or on a farm.¹³

People who work one hour or more without pay are also considered employed by the ABS provided that they work in a family business or on a family farm.

In considering workforce participation by people with mental illness, the Committee determined that it is important to take into account different ways that people with mental illness can be employed.

For example, jobs can be in supported work environments (supported employment) or within mainstream work settings (competitive employment).

- Supported employment—when jobs are specifically tailored for people with mental illness and supports are built into the workplace environment to assist people in maintaining their employment.
- Competitive employment—when people with mental illness compete with workers with no mental illness to secure employment in the open labour market.¹⁴

11 *Transcript of evidence 8*, Open Minds, 21 November 2011, p.4.

12 Abhayaratna, J. & Lattimore, R. (2006) *Workforce participation rates—How does Australia compare? Staff working paper*. Canberra, Productivity Commission, Commonwealth of Australia, p.1.

13 Australian Bureau of Statistics (2011) *Labour force, December 2011 (Catalogue. no. 6202.0)*. Canberra, Australian Bureau of Statistics, p.37.

14 Waghorn, G. & Lloyd, C. (2005) 'The employment of people with mental illness'. *Australian e-Journal for the Advancement of Mental Health*, Vol. 4, No. 2 (supplement), pp.1-43, p.5.

In competitive employment, workers are paid at or above minimum wages, work is performed alongside workers without mental illness and the job can be filled by any appropriately qualified worker.¹⁵ By contrast, in supported employment, jobs may be created specifically for people with disability or mental illness and workers may be paid productivity or competency based wages.

Another important consideration in the context of workforce participation by people with mental illness is whether employment is full-time (35 hours or more each week) or part-time.

Sometimes part-time employment can be an indicator of under-employment. This is when people work fewer hours than they want, and are available to work.¹⁶ In September 2011, there were more than 188,400 under-employed part-time workers in Victoria.¹⁷ However, it is unclear whether, or how many, of these under-employed workers were people with mental illness.

Some researchers suggest that under-employment has a negative impact on mental health.¹⁸ There is also some evidence from the United Kingdom (UK) to suggest that people with mental illness who are in the workforce are more likely to be under-employed than other workers.¹⁹ However, some people may work part-time because they choose to do so for personal, family, or health reasons.

Importantly, the Committee heard that not all people with mental illness want to work full-time hours of employment. SANE stated in its submission that 'having a mental illness can make it difficult to work full-time, and part-time work is often more suitable.'²⁰ Part-time work may be more suitable for people with mental illness who experience effects on stamina, concentration, and energy levels associated with taking medication (see Chapter 1, Section 1.1.1).

In fostering workforce participation by people with mental illness, the Committee considered that it is important to create opportunities for people with mental illness to work part-time and in jobs with flexible work arrangements. The Committee identified that it is also important to create opportunities for people to gradually return to work. For example, in its submission to the House of Representatives Standing Committee on Education and Employment Inquiry into mental health and workforce participation (the 'Federal Inquiry'), Social Firms Australia (SoFA) highlighted that:

For some people returning to the workforce after many years of ill health as few as four hours each week is better for their mental health, with a gradual increase in hours over the months and years.²¹

15 Waghorn & Lloyd (2005) 'The employment of people with mental illness', p.5.

16 Australian Bureau of Statistics (2011) *Underemployed workers, September 2011 (Catalogue no. 6265.0)*. Canberra, Australian Bureau of Statistics, p.2.

17 Australian Bureau of Statistics (2011) *Underemployed workers, September 2011 (Catalogue no. 6265.0)*, p.23.

18 Dooley, D. (2003) 'Unemployment, under-employment and mental health: Conceptualising employment status as a continuum'. *American Journal of Community Psychology*, Vol. 32, No. 1/2, pp.9-20, p.14.

19 Lelliott, Tulloch, Harvey et al. (2008) *Mental health and work: A report for the cross government health, work and well-being program*, p.8.

20 Submission 7, SANE, p.3. See also SANE (2006) *Research bulletin 3: Employment and mental illness*, p.1.

21 Social Firms Australia (2011) *Response to the inquiry into mental health and workforce participation*, submission to the House of Representatives Standing Committee on Education and Employment, Parliament of Australia, Inquiry into mental health and workforce participation, p.5.

Similarly, the Mental Illness Fellowship of Victoria (MI Fellowship) told the Federal Inquiry that:

Many of the people we work with need a very slow start to employment of around three or four hours a week ... It is not unusual for us to be placing people who have been out of the workforce for more than ten years or who became ill during their teens and have never worked. It is a significant step for these people to get up the courage to move into employment where they need to be in places at set times and to undertake focused activity in an unfamiliar environment.²²

Finally, in fostering workforce participation by people with mental illness, the Committee determined that it is important to also focus on supporting those in the workforce to stay well so that they can participate to their full potential. For example, analysis by the Boston Consulting Group (BCG) estimates that mental illness among workers in Victoria is responsible for approximately 4.7 million days of sickness absence a year.²³

Inquiry participants suggested that greater awareness of mental health issues within workplaces and more support for employees experiencing mental illness could help people to remain well and stay at work. Citing the findings of the University of Queensland's Work Outcomes Research Cost Benefit Project, the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) told the Committee that:

Every dollar spent on identifying, supporting and case-managing workers with mental health issues yields close to a 500 per cent return in improved productivity through increased work output and reduced sick and other leave.²⁴

2.3 Rates of workforce participation

Despite the importance of employment for people with mental illness, the Committee found that rates of workforce participation among people with mental illness are low. It identified, however, that the data measures for determining participation rates have limitations. These relate to how surveys define labour force participation and the focus of different surveys on different groups of people with mental illness. The Committee discovered that current statistics regarding the labour force participation among people with mental illness may distort the full extent to which people with mental illness who are willing and able to work are excluded from employment.

2.3.1 Estimates of workforce participation

Inquiry participants told the Committee that the statistics on the number of people with mental illness who are excluded from employment are 'unacceptably high'.²⁵ Associate Professor Carol Harvey from the Psychosocial Research Centre (PRC) explained that there has been little improvement in workforce participation rates among people with severe mental illness, such as schizophrenia, over the past 15 years. This is despite improvements in mental health service delivery during this period.²⁶

22 Mental Illness Fellowship of Victoria (2011) *Response to the inquiry into mental health and workforce participation*, submission to the House of Representatives Standing Committee on Education and Employment, Parliament of Australia, Inquiry into mental health and workforce participation, p.9.

23 Boston Consulting Group (2006) *Improving mental health outcomes in Victoria: The next wave of reform—Report to the Government of Victoria*, p.12.

24 *Submission 41*, Victorian Equal Opportunity and Human Rights Commission, p.4.

25 For example, see *Submission 43*, Social Firms Australia, p.2.

26 *Transcript of evidence 17*, Psychosocial Research Centre, 28 February 2012, p.2.

VEOHRC also expressed concern about a decline in the rate of employment among people with disability (including mental illness). It stated that Australia is now ‘below the Organisation for Economic Co-operation and Development (OECD) average.’²⁷

A 2007 Productivity Commission study reports that mental illness is the health condition ‘associated with the lowest likelihood of being in the labour force, especially for males.’²⁸ This is despite the reality that most people with mental illness want to work and are capable of doing so. For example, in a 2006 survey by SANE, 80 per cent of mental health consumers surveyed said that they were either employed or wanted to work.²⁹

Estimates for Victoria

The Committee identified that published data on labour force participation rates among people with mental illness is largely only available at a national level. It found that recent Victorian data on workforce participation by people with mental illness is limited.

Victorian specific data was reported to the Victorian Government in 2006 by the BCG in a report titled *Improving mental health outcomes in Victoria: The next wave of reform*. According to the report:

- labour force participation by Victorians with mental illness ranged from 28 per cent among people with schizophrenia to 54 per cent among those with moderate levels of psychiatric disability
- labour force participation by Victorians with no mental illness was approximately 72 per cent.³⁰

The Committee noted, however, that these estimates are based on 1990s data produced by the ABS.

FINDING 2

That recent Victorian data related to workforce participation by people with mental illness is limited.

National estimates

At a national level, recent data on workforce participation rates among people with mental illness comes from several sources:

- the ABS Disability, ageing, and carers surveys
- the ABS 2007 *National survey of mental health and wellbeing* (NSMHW)
- the Commonwealth Government’s national survey report on *People living with psychotic illness 2010*.

27 Submission 41, Victorian Equal Opportunity and Human Rights Commission, p.4.

28 Laplagne, P., Glover, M., & Shomos, A. (2007) *Effects of health and education on labour force participation: Staff working paper*. Canberra, Productivity Commission, Commonwealth of Australia, p.10.

29 Submission 7, SANE, p.3. See also SANE (2006) *Research bulletin 3: Employment and mental illness*, p.1.

30 Boston Consulting Group (2006) *Improving mental health outcomes in Victoria: The next wave of reform—Report to the Government of Victoria*, p.12. See also Department of Human Services (2009) *Because mental health matters: Victorian mental health reform strategy 2009-2019*. Melbourne, Mental Health and Drugs Division, Department of Human Services, State of Victoria, p.33.

Table 2.1 shows national estimates for the unemployment and labour force participation rates among people with mental illness compared to people with no mental illness.

Table 2.1: Estimates of labour force participation by people with mental illness (MI)

Data source	Labour force participation rate (%)		Unemployment rate (%)	
	People with MI	People without MI	People with MI	People without MI
Australian Bureau of Statistics (ABS) 2003 <i>Disability, ageing, and carers survey</i> ³¹	28.2	80.6	19.5	5.0
Productivity Commission modelling based on HILDA 2001–04 surveys ³²	39.3	80.7	-	-
ABS 2007 <i>National survey of mental health and wellbeing</i> ³³	73.3	78.4	4.0	2.7
ABS 2009 <i>Disability, ageing, and carers survey</i> ³⁴	42.0	82.8	-	-
<i>People living with psychotic illness 2010</i> ³⁵	30.5	65.3	27.4	5.0

Source: Compiled by Family and Community Development Committee.

These estimates show that people with mental illness are much less likely than people with no mental illness to be participating in the workforce. They also show that people with mental illness are more likely to be unemployed than people with no mental illness.

Surveys also suggest that people with mental illness are more likely to work on a part-time basis than people with no mental illness. For example:

- 36.9 per cent of people with mental illness who were employed in the NSMHW worked in part-time employment. This compared with 33 per cent of people in employment with no mental illness.³⁶

31 Reported in Department of Education, Employment and Workplace Relations (2009) *National mental health and disability employment strategy*. Canberra, Department of Education, Employment and Workplace Relations, Commonwealth of Australia, p.6.

32 Reported in Laplagne, Glover, & Shomos (2007) *Effects of health and education on labour force participation: Staff working paper*, p.9. HILDA refers to the Household, Income and Labour Dynamics in Australia surveys undertaken by the Melbourne Institute of Applied Economic and Social Research at the University of Melbourne.

33 Reported in Australian Bureau of Statistics (2009) *Australian social trends, March 2009* (Catalogue no. 4102.0). Canberra, Commonwealth of Australia, p.15.

34 Reported in Department of Health and Ageing (2012) *Ten year roadmap for national mental health reform: Draft for consultation*. Canberra, Department of Health and Ageing, Commonwealth of Australia, p.34.

35 Morgan, A.J., Wattereus, A., Jablensky, A. et al. (2011) *People living with psychotic illness 2010*, report for the Department of Health and Ageing, Commonwealth of Australia.

36 Australian Bureau of Statistics (2008) *National survey of mental health and wellbeing 2007: Summary of results* (Catalogue no. 4326.0). Canberra, Australian Bureau of Statistics, p.31.

- In the *People living with psychotic illness 2010* survey, more than 63 per cent of those who were employed were employed on a part-time basis.³⁷

However, the Committee identified that it is difficult to determine if the high rate of part-time employment among people with mental illness is an indicator that they are working fewer hours than they want, or are able, to work. As highlighted earlier, some people with mental illness may prefer to work on a part-time basis whereas others do not have the capacity to work full-time.

FINDING 3

That people with mental illness have a much lower workforce participation rate than those with no mental illness.

FINDING 4

That people with mental illness who are in employment are less likely to work full-time. However, it is unclear whether this is because many people with mental illness prefer to work in part-time employment or whether it reflects high under-employment among workers with mental illness.

2.3.2 Data limitations

The Committee identified issues in interpreting the different estimates reported in Table 2.1. It found that there is a lack of succinct definitions in surveys to capture the importance of issues regarding the participation of people with mental illness in employment.

Importantly, the labour force participation rate in surveys reflects ‘the share of the working age population who are either in a job or actively looking for one.’³⁸ The Committee found that this way of measuring workforce participation by people with mental illness may hide the full extent to which people with mental illness who are willing and capable of work are excluded from employment. This is because the labour force participation rate includes both those who are employed and those who are unemployed as participating in the workforce.

Another issue is that different surveys focus on different groups of people with mental illness. For example, the NSMHW only includes people with high-prevalence mental illness. People with schizophrenia and other low-prevalence mental illness were not included in the survey. The *People living with psychotic illness 2010* report, on the other hand, has a specific focus on people with schizophrenia and other psychoses.

The ABS Disability, ageing, and carers surveys focus on people who identify as having disability that is caused by a mental or behavioural condition.³⁹ However, Inquiry

37 Morgan, Wattereus, Jablensky et al. (2011) *People living with psychotic illness 2010*, p.128.

38 Abhayaratna & Lattimore (2006) *Workforce participation rates—How does Australia compare? Staff working paper*, p.1.

39 Australian Bureau of Statistics (2009) *Disability, ageing, and carers Australia 2009: Summary of findings* (Catalogue. no. 4430.0). Canberra, Australian Bureau of Statistics, p.14. In the survey, a person was considered to have disability ‘if they report[ed] they ha[d] a limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities.’ Australian Bureau of Statistics (2009) *Disability, ageing, and carers Australia 2009: Summary of findings* (Catalogue. no. 4430.0), p.27.

participants told the Committee that people with mental illness may not identify as having disability.⁴⁰ This is illustrated by the low incidence of people who report disability caused by mental or behavioural conditions. In 2009, just over three per cent of the population reported having disability caused by mental or behavioural conditions.⁴¹ As outlined in Chapter 1, the proportion of Victorians with mental illness is significantly higher than this figure.

It is clear to the Committee that estimates regarding the labour force participation rate among people with mental illness are not precise and that more consistent and detailed reporting is needed. Workforce participation is an important and emerging issue. Consistency is needed in the reporting of labour force participation and unemployment rates among people with mental illness if progress towards the achievement of workforce participation targets among people with mental illness is to be monitored.

FINDING 5

That statistics may under-report the extent to which people with mental illness who are able and looking for work are excluded from employment.

FINDING 6

That estimates of the labour force participation and unemployment rates among people with mental illness vary across surveys due to differences in how surveys define people with mental illness.

→ RECOMMENDATION 2.1:

That the Victorian Government takes a lead role in liaising with the Commonwealth Government and the Australian Bureau of Statistics (ABS) to establish a consistent approach to defining people with mental illness in surveys for the purposes of measuring unemployment and labour force participation rates among people with mental illness.

⁴⁰ Submission 18, Orygen Youth Health, p.4.

⁴¹ Australian Bureau of Statistics (2009) *Disability, ageing, and carers Australia 2009: Summary of findings* (Catalogue. no. 4430.0), p.9.

2.4 Impacts of low workforce participation

The consequence of high unemployment and non-participation among people with mental illness is that society does not experience the full benefits of workforce participation by people with mental illness. For example, the 2007 OECD report, *Sickness, disability and work*, identifies that increasing employment among people with mental illness:

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.⁴²

In addition to the benefits of workforce participation for people with mental illness, the Committee found that there are considerable costs to the Victorian community by failing to fully engage people with mental illness in employment. These costs are associated with:

- social isolation, homelessness and poverty
- the cost of providing support services and welfare payments to people with mental illness excluded from employment
- effects of mental illness on the productivity of employees, including sickness absences and reduced work performance related to mental illness.

2.4.1 Impacts on individuals, families and carers

As outlined in Chapter 1, people with mental illness experience high rates of social isolation and homelessness compared with the broader population. The Committee heard that enhancing opportunities for people with mental illness to participate in employment is important not only in reducing poverty among people with mental illness but also social disconnection and homelessness. In this vein, Mission Australia told the Committee that:

Enhancing the employment of people with a mental illness can positively impact on many areas of their lives, including income, overall physical and mental health, sense of self and wellbeing, connectedness to broader community and overall social inclusion levels.⁴³

In its submission, VincentCare pointed to the high rates of homelessness among people with mental illness and the importance of employment in enabling people to break 'long-term cycles of homelessness'.⁴⁴ The Royal Australian and New Zealand College of Psychiatrists (RANZP) similarly drew attention to the role of employment in assisting people to sustain housing. RANZP suggested that mental illness can play a key part in homelessness partly 'through the loss of employment from the effects of a disorder like anxiety or depression ...'⁴⁵

42 Organisation for Economic Co-operation and Development (OECD) (2007) *Sickness, disability and work: Breaking the barriers, Vol 2.—Australia, Luxembourg, Spain and the United Kingdom*. Luxembourg, Organisation for Economic Co-operation and Development, p.19. Cited in House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*. Canberra, Parliament of the Commonwealth of Australia, p.7.

43 *Submission 29*, Mission Australia, p.6.

44 *Submission 28*, VincentCare Victoria, p.10.

45 *Submission 14*, The Royal Australian and New Zealand College of Psychiatrics (RANZP)—Victorian Branch, p.5.

Several Inquiry participants drew attention to the consequences of unemployment for people's self-esteem and social inclusion. For example, the Victorian Mental Health Carers Network (VMHCN) identified the following costs to people with mental illness from non-participation:

Low esteem, low income, social isolation, dependence, greater chance of relapse (including psychiatric crisis and suicide), poor physical health, greater chance of resorting to drugs.⁴⁶

The Committee heard that low workforce participation also affects the employment and income of family members and those who support people with mental illness in caring roles.⁴⁷ For example, *beyondblue* highlighted that:

It is important to acknowledge that carers of people with a mental illness also face barriers to participating in employment. Carers are significantly less likely to participate in full and part time employment compared to those in the general community, due to their carer responsibilities. Carers are also more worried than the general community about the prospect of losing their job, due to the impact this may have on their caring role, and the challenges associated with finding a job that can fit in with caring responsibilities.⁴⁸

ABS data shows that, in 2003, the labour force participation rate of primary carers was just 39 per cent.⁴⁹ Open Minds advised the Committee that 'mental health carers spend an average of 104 hours per week caring for someone with a mental illness.' Based on national trends, Open Minds estimated that there are around 303,600 Victorian carers who are not in the workforce.⁵⁰ Carers' non-participation in the workforce comes at considerable expense to their household incomes. For example, in 2001, Access Economics estimated that carers of people with schizophrenia in Australia experienced lost earnings totalling \$82.8 million as a direct consequence of the impacts of caring on their participation in employment.⁵¹

FINDING 7

That fostering workforce participation by people with mental illness benefits individuals, families and carers through reducing social exclusion, poverty and homelessness and enabling carers to participate more fully in employment.

2.4.2 Costs to government and the economy

The Committee identified that fostering workforce participation by people with mental illness can produce substantial societal and economic benefits. For example,

46 Submission 26, Victorian Mental Health Carers Network, p.4.

47 Australian Bureau of Statistics (2004) *Disability, ageing, and carers Australia 2003* (Catalogue no. 4430.0). Canberra, Australian Bureau of Statistics, p.11.

48 Submission 19, *beyondblue*, pp.7-8. In its submission, *beyondblue* cited a 2007 survey on carer health and wellbeing by the Australian Centre for Quality of life which suggests that more than one in five carers are unemployed. See Cummins, R., Hughes, J., Tomy, A. et al. (2007) *The wellbeing of Australians: Carer health and wellbeing*. Melbourne, Australian Centre on Quality of Life, Deakin University.

49 Australian Bureau of Statistics (2004) *Disability, ageing, and carers Australia 2003* (Catalogue no. 4430.0), p.11.

50 Response to questions on notice, Open Minds, 23 January 2012, pp.1-2.

51 Access Economics (2002) *Schizophrenia: Costs—An analysis of the burden of schizophrenia and related suicide in Australia*. Access Economics and SANE Australia, p.26.

the Committee heard that non-participation among people with mental illness leads to increased costs for government and reduced economic output due to:

- the cost of providing health and welfare services to people with mental illness who are unemployed or not participating in the workforce
- lost productivity and economic output over time from working age people with mental illness not participating in employment.

Associate Professor Harvey suggested that ‘lost earnings, government tax foregone and welfare pension costs’ associated with unemployment among people with psychosis alone account for half the total economic costs related to psychotic illness in Australia.⁵²

This is supported by analysis of the total economic cost of mental illness in Victoria carried out by the BCG in 2006. This analysis found that the overall costs associated with mental illness in Victoria in 2006 totalled more than \$5 billion. However, spending on welfare payments and reduced economic output due to loss of earnings among people with mental illness not participating in the workforce accounted for over \$3 billion of this cost.⁵³

Health costs

Non-participation hinders recovery. This leads to people with mental illness requiring lengthier treatment from specialist mental health services. As the Executive Director and Clinical Director of Mental Health, Drug and Alcohol Services at Barwon Health, Dr Tom Callaly, told the Committee:

About 95 per cent of the people that we actually case manage are unemployed, and unemployment and not having occupational activities is known and has always been known to contribute greatly to the difficulty in improving with severe mental illness. So we have a sort of interactive process where not being able to work, not being able to get into the workforce or have some activity such as that is obviously going to affect the progress of a severe illness and, on the other hand, the illness itself interferes with a person’s ability to get into the workforce.⁵⁴

By contrast, evidence suggests that participation in employment can reduce mental health service usage and costs among people with mental illness, although it is difficult to estimate by precisely how much.⁵⁵ The findings of a Sainsbury Centre for Mental Health report on the benefits of providing Individual Placement and Support (IPS) vocational assistance to clients of mental health services in the UK provide an indication of the savings that can be achieved. This report estimates that delivering such employment support to people with mental illness can result in savings of around £6,000 (AUD\$9,232) per client in inpatient costs over an 18-month period.⁵⁶

52 *Transcript of evidence 17*, Psychosocial Research Centre, p.3.

53 Boston Consulting Group (2006) *Improving mental health outcomes in Victoria: The next wave of reform—Report to the Government of Victoria*, p.13.

54 *Transcript of evidence 1*, Barwon Health & Pathways Rehabilitation and Support Services, 4 November 2011, p.2.

55 Perkins, R., Farmer, P., & Litchfield, P. (2009) *Realising ambitions: Better employment support for people with a mental health condition—A review to government*. London, Disability and Work Division, United Kingdom Government Department for Work and Pensions p.60.

56 Sainsbury Centre for Mental Health (2009) *Briefing 41: Commissioning what works—The economic and financial case for supported employment*. London, Sainsbury Centre for Mental Health, p.5.

This illustrates the importance of assisting people who use mental health services to return to work as part of their journey to recovery. Chapter 8 outlines how mental health services in Victoria can work with employment services and employers to support the vocational rehabilitation of people who use their services.

Income support

The costs associated with income support and low workforce participation by people with mental illness were identified in the Federal Inquiry. Data presented to the Federal Inquiry by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) showed that, in June 2010, almost a third (28.7 per cent) of people receiving the Disability Support Pension (DSP) had mental illness as their primary condition.⁵⁷

The Federal Inquiry Report notes that nationally:

- The number of DSP recipients with psychiatric or psychological conditions recorded as their primary condition has grown by more than 76 per cent over the past decade.
- In 2009–10, the cost of providing the DSP to people with mental illness was estimated at \$3 billion.⁵⁸

For Victoria, the BCG identified that there were approximately 36,000 Victorians with mental illness receiving the DSP in 2006. The cost of providing these DSP payments was estimated at \$370 million.⁵⁹

Lost economic output

Non-participation in the workforce leads to reduced earnings, which affects overall economic output through the lost productivity that reduced earnings represent and the wider impacts of lower earnings on people's consumption of goods and services.

In 2006, the BCG report calculated that there were around 73,000 Victorians aged 18 to 65 years who were not participating in the workforce due to mental illness. This represented an annual loss of economic output to Victoria of approximately \$2.7 billion in terms of the additional income that could be generated were these Victorians participating in the workforce.⁶⁰

FINDING 8

That increasing workforce participation among people with mental illness can reduce government expenditure on health and welfare services and increase economic output over time.

57 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.3.

58 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.3.

59 Boston Consulting Group (2006) *Improving mental health outcomes in Victoria: The next wave of reform—Report to the Government of Victoria*, p.12.

60 Boston Consulting Group (2006) *Improving mental health outcomes in Victoria: The next wave of reform—Report to the Government of Victoria*, p.12.

During the Inquiry, the Committee heard evidence about the importance of employment in assisting the rehabilitation of ex-prisoners and reducing the risk of re-offending. This is discussed in Box 2.1.

Box 2.1 The importance of supporting ex-prisoners to return to employment

WISE Employment informed the Committee about a program it operated between 2002 and 2006 that provided long-term support for up to three years to ex-offenders to assist them to find and maintain employment.

Mr John Bateup, Chief Executive Officer of WISE, advised the Committee that 30 per cent of the 336 program participants 'had a diagnosed mental illness.'⁶¹ He explained that, with long-term support provided upon release, the program 'reduced the recidivism rate to 14 per cent over three years ... which is well below the norm of around 65 per cent for those without assistance ...'⁶²

Mr David Christian, Community Investment Manager with WISE, estimated that the program delivered a nine-to-one return on investment in terms of the social benefits realised by the program. These included 'people not going to prison, earning wages, contributing taxes and not using the health system ...'⁶³

The Committee heard that early engagement with prisoners prior to their release was critical to the success of the program. Mr Christian explained that, through contact with prisoners prior to their release, 'people identify that they have got a sympathetic service that understands how to work with people who have got criminal histories ... and that helps to provide stability and continuity once they are out.'⁶⁴

Source: Compiled by Family and Community Development Committee.

→ RECOMMENDATION 2.2:

That the Victorian Government evaluate the increased social benefits and value for spend delivered by programs that decrease recidivism.

2.4.3 Costs to business and employers

Fostering workforce participation by people with mental illness involves supporting those already in the workforce to stay well and participate to their full potential as well as creating employment pathways for those who are unemployed.

Inquiry participants suggested that flexible work arrangements and supportive work environments that facilitate help seeking and disclosure of mental illness can assist people with mental illness to stay at work. In the absence of these supports, employees can experience a decline in their health which results in employees having to take more time off work. For example, modelling by Ernst and Young based on ABS data indicates that young men with mental illness such as depression and anxiety take an additional 9.5 days of personal leave per year compared with the general population.⁶⁵ This creates costs for business and employers. For example, the BCG estimated that work absences related to mental illness were responsible for around 4.7 million lost

61 *Transcript of evidence 16*, WISE Employment, 28 February 2012, p.4.

62 *Transcript of evidence 16*, WISE Employment, p.4.

63 *Transcript of evidence 16*, WISE Employment, p.8.

64 *Transcript of evidence 16*, WISE Employment, p.10.

65 Degney, J., Hopkins, B., Hosie, A. et al. (2012) *Counting the cost: The impact of young men's mental health on the Australian economy*. Inspire Foundation and Ernst & Young, p.16.

working days in Victoria in 2006. This cost employers approximately \$660 million in lost productivity.⁶⁶

The Committee learned that stigma associated with mental illness, however, means that people with mental illness can be reluctant to take time off work when they are unwell for fear of having to disclose their mental illness. Instead they come to work sick. This also creates costs for employers as the speed at which people are able to complete work tasks can be affected by their symptoms.

Significantly, a recent report by the Victorian Health Promotion Foundation (VicHealth) suggests that depression alone costs employers nationally over \$3.4 billion per year in terms of lost productive time caused by employees taking time off work or coming to work sick.⁶⁷ Across the spectrum of mental illness, the *National mental health report 2010* suggests that the cost to employers of lost productive time is about \$5.9 billion per year.⁶⁸

These findings illustrate the importance of early intervention and support in workplaces to ensure that employees with mental illness remain well and stay at work. In this vein, several Inquiry participants suggested that Australian businesses may lose as much as \$6 billion per year through failing to respond appropriately when employees experience mental health problems.⁶⁹

FINDING 9

That supporting people with mental illness in the workplace to remain well and participate to their full potential can benefit employers through retention of skills and reducing productivity loss by reducing unscheduled leave.

Chapter 7 discusses approaches that businesses can take in intervening early and providing support to employees with mental illness to assist them to stay well and maintain their employment. The Chapter also considers the importance of addressing factors within the workplace that can contribute to or exacerbate mental illness, such as job strain and workplace bullying.

Although employment is generally associated with improved mental health, poor psychosocial and stressful working conditions can lead to mental injury within the workplace. Work-related mental health problems, or mental injuries, are associated with early exits from work as well as costs to employers in terms of WorkCover premiums. Box 2.2 outlines these costs in more detail.

66 Boston Consulting Group (2006) *Improving mental health outcomes in Victoria: The next wave of reform—Report to the Government of Victoria*, p.12.

67 LaMontagne, A. & Sanderson, K. (2010) *Estimating the economic benefits of eliminating job strain as a risk factor for depression*. Melbourne, Victorian Health Promotion Foundation (VicHealth), p.15.

68 Department of Health and Ageing (2010) *National mental health report 2010: Summary of 15 years of reform in Australia's mental health services under the national mental health strategy 1993-2008*. Canberra, Department of Health and Ageing, Commonwealth of Australia, p.32.

69 Submission 7, SANE, p.10; Submission 23, Pathways Rehabilitation and Support Services & Barwon Health, p.5.

Box 2.2 Costs of work stress and mental injury claims

The Committee heard that mental health problems caused by work conditions are becoming an increasingly significant source of occupational injury and disease.⁷⁰ For example, Associate Professor Anthony LaMontagne from the McCaughey Centre told the Committee that about one-quarter of all working women, and close to one in five working men, are now exposed to job-strain.⁷¹

Job-strain occurs when people work in a demanding job but have little control over how they can do their job. Associate Professor LaMontagne advised the Committee that working in a job-strain situation approximately doubles a person's risk of developing depression. He stated that it also 'more than doubles the risk of early exit from the workforce onto a disability pension.'⁷²

In Victoria, workers who experience mental injury in the workplace related to job-strain or other work-risks to mental health such as bullying and harassment may be eligible for compensation for any medication costs as well as loss of income through the WorkCover scheme. Victoria's WorkCover scheme is administered by WorkSafe Victoria under the *Accident Compensation Act 1985* (Vic) and paid for by employers through premium contributions.

WorkSafe informed the Committee that mental injury claims now represent an increasing proportion of all claims within the Victorian WorkCover scheme. The Committee heard that in the financial year 2010–11, 'some 3,089 individuals lodged a claim for a mental illness'.⁷³ This represented just over 10 per cent of all occupational injury claims lodged that year.

The former Chief Executive Officer of WorkSafe, Mr Greg Tweedly, explained to the Committee that mental injury claims are more costly than physical injury claims.⁷⁴ This is due to the fact that it is more difficult to assist people who experience mental injury to return to work. For example, in 2010–11, the average cost of mental injury claims within the Victorian WorkCover scheme was \$69,000. This compared with an average cost of \$58,000 for physical injury claims. Overall, the total cost of mental injury claims within the Victorian WorkCover scheme amounted to more than \$162 million in the 2010–11 financial year.⁷⁵

Source: Compiled by Family and Community Development Committee.

In view of the substantial social, economic and personal costs related to low workforce participation among people with mental illness, the Committee determined that there is a strong basis for supporting policy responses that foster the workforce participation of people with mental illness.

70 *Submission 41*, Victorian Equal Opportunity and Human Rights Commission, p.5.

71 *Transcript of evidence 24*, Associate Professor Anthony LaMontagne—VicHealth Centre for the Promotion of Mental Health and Community Wellbeing (McCaughey Centre), 7 March 2012, p.3.

72 *Transcript of evidence 24*, Associate Professor Anthony LaMontagne—VicHealth Centre for the Promotion of Mental Health and Community Wellbeing (McCaughey Centre), p.3.

73 *Transcript of evidence 27*, WorkSafe Victoria, 21 March 2012, p.5.

74 *Transcript of evidence 27*, WorkSafe Victoria, p.5.

75 Letter from Mr Ian Forsyth, Acting Chief Executive, WorkSafe Victoria, to Chair, Victorian Parliament Family and Community Development Committee, 19 September 2012, p.1.

Chapter Three: Leading a response to increase workforce participation

Findings

1. That improving workforce participation by people with mental illness requires a joined-up approach across departments within Victoria and cooperation between Victorian and Commonwealth governments to address the disconnection between service sectors.
2. That the Victorian and Commonwealth governments have overlapping roles and responsibilities in key policy areas affecting workforce participation by people with mental illness.
3. That Victorian Government initiatives to foster workforce participation by people with mental illness have achieved some progress, but a greater focus is required on:
 - Addressing obstacles to employers recruiting and retaining workers with mental illness such as attitudes towards mental illness in the workplace and workplaces' capacity to manage employees with mental illness.
 - Early intervention and prevention in education and in workplaces.
 - Responding to barriers to workforce participation experienced by people with higher-prevalence mental illness.

This chapter considers the role of the Victorian Government in addressing the costs associated with low workforce participation by people with mental illness.

Responsibility for workplace participation and mental health rests across Commonwealth and state governments. The Commonwealth Government has a primary role in income support, employment services and primary mental health. The Victorian Government has primary responsibility for mental health treatment services, occupational health and safety, and education and training.

In 2010, the Victorian Government made an election commitment to improve workforce participation by people with mental illness. It stated its goal was to lift the employment rate among people with mental illness from 29 to 50 per cent by 2020.¹

To achieve its objectives in lifting workforce participation, the Committee has suggested that the Victorian Government establishes a mental health employment strategy.

The Committee determined that cooperation between State and Commonwealth Governments is important in view of their overlapping responsibilities across areas that influence the workforce participation of people with mental illness.

3.1 Policy context

In its pre-election commitment, the Victorian Government emphasised the importance of:

- increasing workforce participation by people with mental illness
- tackling workplace stress
- encouraging appropriate support in workplaces for people with mental illness.

Several Inquiry participants also identified the right of people with disability (including mental illness) to participate in employment on an equal basis. The United Nations Convention on the Rights of Persons with Disabilities (UN Convention) establishes this right. The Acting Commissioner of the Victorian Equal Opportunity and Human Rights Commission (VEOHRC), Ms Karen Toohey, told the Committee that the UN Convention establishes a high standard for taking action to promote the employment of people with mental illness.²

Table 3.1 provides an overview of Article 27 of the UN Convention, which sets out the rights of people with disability in the context of work and employment.

1 Liberal Victoria & The Nationals for Regional Victoria (2010) *The Victorian Liberal Nationals Coalition Plan for Mental Health*. Melbourne, The Victorian Liberal Nationals Coalition's Policy and Plans for the 2010 State Election, p.21.

2 *Transcript of evidence 10*, Victorian Equal Opportunity and Human Rights Commission, 21 November 2011, p.2.

Table 3.1: United Nations Convention on the Rights of Persons with Disabilities

Convention	Overview
United Nations Convention on the Rights of Persons with Disabilities	<ul style="list-style-type: none"> • Ratified by Australia on 17 July, 2008. • Defines persons with disability as including ‘those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.’
Article 27—Work and Employment	<ul style="list-style-type: none"> • Article 27 establishes ‘the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to persons with disabilities.’ • Article 27 goes on to state that ‘parties shall safeguard and promote the realization of the right to work,’ through taking action to: <ul style="list-style-type: none"> • Prohibit discrimination on the basis of disability with regard to all matters concerning all forms of employment • Enable persons with disabilities to have effective access to general technical and vocational guidance programs, placement services and vocational and continuing training • Promote employment opportunities and career advancement for persons with disabilities in the labour market, as well as assistance in finding, obtaining, maintaining and returning to employment • Promote opportunities for self-employment, entrepreneurship, the development of cooperatives and starting one’s own business • Employ persons with disabilities in the public sector • Promote the employment of persons with disabilities in the private sector through appropriate policies and measures, which may include affirmative action program and incentives • Promote vocational and professional rehabilitation, job retention and return-to-work programmes for persons with disabilities.

Source: Compiled by Family and Community Development Committee from United Nations (2012). *Convention on the Rights of Persons with Disability and Optional Protocol*. Accessed on 24 July 2012 from <http://www.un.org/disabilities/documents/convention/convoptprote.pdf>.

3.2 Role of government

The Inquiry Terms of Reference ask the Committee to consider the respective roles and intersections of local, state, and Commonwealth governments in supporting workforce participation of people with mental illness.

The Committee determined that local governments can help to foster workforce participation of people with mental illness through social procurement policies and practices. These are described in Chapter 6. However, the Committee identified that governments at state and federal levels have key responsibility for areas that influence the workforce participation of people with mental illness.

Workforce participation is influenced by complex and interrelated factors in the economy and the community, including:

- education and training
- the structure of employment support services
- welfare policy
- workplace relations
- occupational health and safety
- equal opportunity and anti-discrimination
- mental health services.

State and Commonwealth governments have responsibility for policy development, funding, administration, and service provision in these areas. Due to the overlapping roles of governments, the Committee identified the significance of coordinated action by the Victorian and Commonwealth Governments across multiple policy settings and different service systems.

Participants identified that coordination of services in specialist mental health, employment support, and education and training is critical. This coordination is necessary to address the complex vocational and non-vocational barriers to participation experienced by many people with mental illness.

Achieving a coordinated approach to service delivery across state and federal governments is particularly complex due to funding arrangements and responsibilities for policy development. The Committee heard that ‘the split of responsibilities across federal and state governments, and across government departments, is contributing to poor coordination and “service silos”’.³

Prahran Mission highlighted the lack of inter-sectoral collaboration and sharing of information between mental health services funded by the Victorian Government and Commonwealth-funded employment services.⁴ The Brotherhood of St Laurence (BSL) explained that:

There is a very fragmented array of services and programs available at federal, state and [community] levels. They all have their own eligibility criteria, and that then targets a particular form of intervention which is not necessarily responsive and integrated enough for the individual.⁵

³ *Submission 19, beyondblue*, p.6.

⁴ *Submission 15, Prahran Mission UnitingCare*, p.4.

⁵ *Transcript of evidence 14, Brotherhood of St Laurence*, 28 February 2012, p.7.

The Committee also observed that there is increasing overlap and duplication in the roles and responsibilities of different levels of government in certain areas, especially mental health. The Committee identified the importance of establishing liaison roles within health services to increase coordination and collaboration with other service sectors. During the Inquiry, the Bendigo Youth Support and Advocacy Service (YSAS) explained how it had successfully supported a client with bi-polar disorder to gain employment through coordinating with his clinical care team and linking him into Commonwealth-funded employment support services.⁶ When the client was placed into employment, the employment service provider linked the employer to YSAS. YSAS provided continuing support to the employer in providing flexible work arrangements and in identifying signs of deterioration in their clients' health.

FINDING 1

That improving workforce participation by people with mental illness requires a joined-up approach across departments within Victoria and cooperation between Victorian and Commonwealth governments to address the disconnection between service sectors.

3.2.1 Commonwealth Government responsibilities

The respective roles and responsibilities of the Commonwealth, state and territory governments for policy setting, funding, service provision and administration in mental health, employment, education and several other areas are set out in a number of key agreements. These included the Australian Constitution and the National Disability Agreement (formerly known as the Commonwealth, States, and Territories Disability Agreement).

The key policy areas in which the Commonwealth Government has primary influence over the barriers and incentives to workforce participation by people with mental illness include:

- income support
- employment services
- primary health
- personal income and business taxation policy
- workplace relations.

Income support, employment services and primary health are key policy areas that affect the workforce participation of people with mental illness. A large number of people with mental illness use Commonwealth-funded employment and primary care services. In addition, many are in receipt of the Disability Support Pension (DSP).

Income support

Many Inquiry participants explained that the fear of losing income support entitlements can be a factor in the low rate of workforce participation by people with mental illness, particularly given the episodic nature of mental illness. So while a person may be well enough to enter employment, *beyondblue* explained there is a

⁶ Transcript of evidence 7, Youth Support and Advocacy Service (YSAS), 18 November 2011, pp.6-7.

concern that they ‘may not be able to maintain ongoing employment, and will then be left on a lower income once their period of employment ends ...’⁷

The Commonwealth Government has responsibility for policy, funding, and management of income support.

The main form of income support available to people with mental illness is the DSP. The eligibility requirements stipulate that people can receive the DSP if they are assessed as having:

- a physical, intellectual, or psychiatric impairment lasting more than two years
- are unable to work without program support for at least 15 hours or more per week at or above the relevant minimum wage.⁸

As outlined in Chapter 2, approximately 28.7 per cent of DSP recipients had a mental illness as their primary condition at June 2010.⁹ In the last decade, the numbers of DSP recipients with mental illness has grown by more than 76 per cent.

Employment support services

The quality of job search assistance and employment support services delivered to people with mental illness is a critical factor in determining the ability of people with mental illness to enter and remain in employment. As Dr Geoff Waghorn from the Queensland Centre for Mental Health Research told the Committee, ‘an effective employment service can overcome all the disadvantages and work restrictions at an individual level.’¹⁰

The Commonwealth Government has primary responsibility for employment support services for people with mental illness. It funds Job Services Australia (JSA) and Disability Employment Services (DES). Table 3.2 outlines these programs.

The Commonwealth Government also provides incentives for employers to recruit job seekers with a disability or mental illness in the form of:

- Wage subsidies—employers who recruit DES clients are eligible for a one-off wage subsidy payment of \$3,000.
- Supported Wage System—allows employers to pay productivity-based wages in lieu of full award wages to employees whose productivity is significantly reduced due to the effects of their disability or mental illness.
- Employment Assistance Fund—provides funding to cover the costs of modifications to the work environment that are needed to enable the employment of a worker with disability or mental illness.

JSA and DES focus on helping people find and sustain work in the open labour market. They are delivered by a range of small, medium and large for-profit and

7 Submission 19, *beyondblue*, p.7.

8 Department of Education, Employment and Workplace Relations, Department of Health and Ageing, & Department of Families, Housing, Community Services and Indigenous Affairs (2011) *Response to the inquiry into mental health and workforce participation*, joint submission to the House of Representatives Standing Committee on Education and Employment, Parliament of Australia, Inquiry into mental health and workforce participation, p.21.

9 House of Representatives Standing Committee on Education and Employment (2012) *Work Wanted: mental health and workforce participation*. The Parliament of the Commonwealth of Australia, Canberra, p.3.

10 Submission 42, Dr Geoff Waghorn—Queensland Centre for Mental Health Research, p.5.

not-for-profit organisations. Under the *Australian Disability Services Act 1986*, the Commonwealth Government also funds Australian Disability Enterprises (ADEs) to provide supported employment services to people:

- for whom competitive employment at or above the relevant award wage is unlikely and
- who need substantial ongoing support to obtain or retain paid employment because of their disabilities.

Table 3.2: Commonwealth-funded employment programs

Program	Details
Job Services Australia (JSA)	<ul style="list-style-type: none"> • Provides job search assistance and support to people with barriers to employment who are receiving income support through Centrelink. • Level of employment support provided depends upon the extent of clients' barriers to participation. • Providers have access to an Employment Pathway Fund to purchase assistance in line with clients' identified individual needs.
Disability Employment Services (DES)	<ul style="list-style-type: none"> • More intensive and specialist employment services for people assessed as having barriers to participation related to disability or ill health. This includes people with mental illness, although people with mental illness often do not identify as having disability. • Approximately 30 per cent of all DES clients are people with mental illness.¹¹ • Consist of two distinct programs: Disability Management Services (DMS) and Employment Support Services (ESS), with the majority of DES clients with mental illness being assisted through ESS.¹² • ESS program clients receive employment services at a higher level of funding and for a longer duration (up to 24 months of post-placement support where there is an assessed need).
Australian Disability Enterprises (ADEs)	<ul style="list-style-type: none"> • Commercial business ventures that trade to provide employment opportunities in a supported environment to around 20,000 people with moderate to severe disability. • Supported employees are often paid productivity or competency based wages which are lower than industry award wage—average gross hourly wage paid to supported employees in ADEs is \$3.61 compared to a national minimum wage of \$15.51 per hour.¹³

Source: Compiled by Family and Community Development Committee.

Chapter 6 considers issues related to employment support services and wage subsidies for employers in fostering pathways into employment for people with mental illness

11 Minister for Health and Ageing, Minister for Families, Housing, Community Services and Indigenous Affairs, & Minister for Mental Health and Ageing (2011) *Budget 2011-12: National mental health reform—Ministerial statement*. Canberra, Commonwealth of Australia, p.29.

12 Senate Standing Committee on Education Employment and Workplace Relations, Parliament of Australia (2011) *Questions on notice budget estimates 2011-2012: Question no. EW0361_12*. Accessed on 19 September 2012 from http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Committees?url=eet_ctte/estimates/bud_1112/answers/EW0361_12.pdf

13 Advisory group on inclusion of people with disability through sustainable supported employment (2012) *Advisory group: vision for sustainable supported employment*. Canberra, Department of Families, Housing, Community Services and Indigenous Affairs, Commonwealth of Australia, pp.26-27.

in greater detail. Inquiry participants highlighted that it is critical to support people with mental illness to look for work as soon as they are motivated to do so. However, the Committee heard that job seekers with mental illness can experience significant delays in accessing appropriate employment support services due to the duration of the assessment process. The Committee also heard that awareness of wage subsidies and other incentives that can assist in recruiting and retaining people with mental illness is low among employers (see Chapter 6, Section 6.3.2).

Primary mental health services

Mental health services have a key role in enabling people with mental illness to participate in employment. Timely treatment and early intervention can prevent mental health problems from developing into more serious mental illness.

Responsibility for policy development, funding, and administration in relation to mental health is shared across the state and Commonwealth governments.

- State governments fund and administer specialist treatment and recovery services that respond to acute symptoms associated with low-prevalence mental illness (see Section 3.2.3).¹⁴
- The Commonwealth Government has a focus on the prevention and treatment of high-prevalence mental illness, such as anxiety and depression.

These funding and administrative arrangements contribute to complexities in service provision, particularly in collaborating across State and Commonwealth service systems.

Through the Medicare Benefits Schedule, the Commonwealth Government funds general practitioners (GPs), private psychiatrists, psychologists and other allied health professionals (mental health nurses, occupational therapists) to provide mental health related treatment services in primary care settings. More than 342,000 Victorians received Medicare funded clinical mental health services in 2008–09, the vast majority of which were provided by GPs.¹⁵

GPs are often the first port of call for people seeking help for mental health issues. GPs have a key role in facilitating referrals to specialist services. In 2007, more than 70 per cent of people who sought medical help for high-prevalence mental illness consulted a GP. By comparison, approximately 38 per cent of people who experienced high-prevalence mental illness in 2007 consulted a psychologist, while just over 24 per cent consulted a psychiatrist (people may have consulted more than one type of health professional).¹⁶ The Committee heard that the advice given by GPs and other health professionals in relation to the impacts of mental illness on people's capacity to work can be critical in influencing people's decisions to work.¹⁷

14 Boston Consulting Group (2006) *Improving mental health outcomes in Victoria: The next wave of reform—Report to the Government of Victoria*. Melbourne, Department of Premier and Cabinet, Victorian Government, pp.17-18.

15 Steering Committee for the Review of Government Service Provision (2012) *Report on government services 2012*. Canberra, Productivity Commission, Table12A.37.

16 Slade, T., Johnston, A., Teesson, M. et al. (2009) *The mental health of Australians 2: Report on the 2007 National survey of mental health and wellbeing*, report for the Department of Health and Ageing, Commonwealth of Australia, p.17.

17 *Submission 15*, Prahran Mission UnitingCare, p.3. See also *Submission 19, beyondblue*, p.12.

The Commonwealth Government also funds youth-focused mental health services, sometimes in conjunction with state governments. These services are provided by headspace centres to people aged 12 to 25 years. The services include integrated:

- primary care services
- allied health services
- mental health services
- drug and alcohol services
- vocational support services.

There are currently 13 headspace centres in Victoria, although the Commonwealth Government has committed to expanding the number of headspace services in Victoria over the next three years.¹⁸

The Committee identified a number of overlapping responsibilities between the Commonwealth and the Victorian Governments. For example, in recent years, the Commonwealth has committed to funding the expansion of early psychosis intervention services, in collaboration with the states and territories.¹⁹ It has also become increasingly involved in funding social support services for people living with severe mental illness. These programs include the Day to Day Support for Living in the Community program and the Personal Helpers and Mentors Scheme (PHaMs).²⁰

The Committee identified that these Commonwealth-funded programs overlap with some of the Psychiatric Disability Rehabilitation Support Services (PDRSS) that the Victorian Government funds.²¹ In many cases, both Commonwealth and State funded programs are being delivered by the same service providers. A recent Victorian Department of Health (DoH) consultation paper on reform of PDRSS stated that the lack of alignment between PHaMs and PDRSS has ‘introduced more entry points, making the mental health service system even more complex for clients, their carers and referring agencies to navigate.’²²

The Chair of the former Victorian Mental Health Reform Council (VMHRC), Mr Terry Laidler, expressed his concern about the duplication of services to the Committee. He stated that the Commonwealth Government is:

Currently expanding what they call their personal helpers and mentors program which is one on one support for people with mental health problems ... They are about to spend \$1.3 billion on what they are calling case coordination

So you know, again, lots of Victorian agencies will be applying for Commonwealth

18 Headspace (2012) *Headspace centres*. Accessed on 10 September 2012 from <http://www.headspace.org.au/headspace-centres>. See also Headspace (2012) *Headspace welcomes announcement of next 15 centre locations*. Accessed on 10 September 2012 from <http://www.headspace.org.au/about-headspace/media-centre/media-releases/headspace-welcomes-announcement-of-next-15-centre-locations>.

19 Prime Minister, Minister for Health and Ageing, & Minister for Mental Health and Ageing, Commonwealth of Australia, *2011-12 Budget offers greater support for mental health patients*, Media release, 25 October 2011.

20 Department of Health (2012) *Psychiatric Disability Rehabilitation and Support Services reform framework: Consultation paper*. Melbourne, Department of Health, State of Victoria, pp.18-19.

21 Department of Health (2012) *Psychiatric Disability Rehabilitation and Support Services reform framework: Consultation paper*, pp.18-19.

22 Department of Health (2012) *Psychiatric Disability Rehabilitation and Support Services reform framework: Consultation paper*, p.26.

money under those two programs. There's a major problem at the moment with lack of coordination between Commonwealth initiatives and state initiatives.²³

The Committee found that overlaps in primary prevention and mental health promotion also exist. The Victorian Government funds mental health promotion and early intervention programs across a range of sectors and settings, including programs in schools and early childhood care settings.²⁴

The Commonwealth also contributes to primary prevention and mental health promotion through its funding of:

- the National Suicide Prevention Strategy
- Mindframe: the National Media Initiative to promote responsible reporting of mental illness
- the MindMatters and KidsMatter mental health promotion programs in schools and early childhood settings.

The national depression initiative, *beyondblue*, is jointly funded by the Commonwealth and the states and territories.

FINDING 2

That the Victorian and Commonwealth governments have overlapping roles and responsibilities in key policy areas affecting workforce participation by people with mental illness.

→ RECOMMENDATION 3.1:

That the Victorian Government takes a lead role in liaising with the Commonwealth to:

- Minimise duplication and funding gaps across Victorian and Commonwealth-funded services and programs.
- Clarify the respective roles of the Victorian and Commonwealth governments in relation to funding and administering mental health services and programs.

Commonwealth Government policy responses

In recent years, the Commonwealth Government has sought to address the low rate of workforce participation by people with mental illness through a range of policy initiatives. These include:

- reforming the way employment services are delivered to people with mental illness
- funding projects aimed at creating employment pathways for people with moderate to severe mental illness in social firms
- removing disincentives to work within the structure of welfare entitlements.

Table 3.3 details the Commonwealth Government's policies and related initiatives to address workforce participation by people with mental illness.

23 Transcript of evidence 4, Victorian Mental Health Reform Council, 7 November 2011, pp.5-6.

24 Department of Human Services (2009) *Because mental health matters: Victorian mental health reform strategy 2009-2019*. Melbourne, Mental Health and Drugs Division, Department of Human Services, State of Victoria, pp.69-70.

Table 3.3: Commonwealth Government responses to workforce participation by people with mental illness

Year	Policy Response	Details
2006	Council of Australian Governments (COAG) National Action Plan on Mental Health 2006–2011	<ul style="list-style-type: none"> Committed to increasing the ability of people with mental illness to participate in the community, including employment, as one of four outcome measures. Provided funding for an additional 900 Personal Helpers and Mentors (PHaMs) to assist people with mental illness living in the community to better manage their daily activities, including in accessing employment support services.
2009	National Mental Health and Disability Employment Strategy	<ul style="list-style-type: none"> Stated a goal to reform the delivery of employment support services to people with mental illness or disability through the introduction of new Disability Employment Services (DES) in March 2010. Plans underway to reform supported employment programs—an advisory group on inclusion for people with disability through sustainable supported employment has been established to provide strategic advice on a new 10-year vision.²⁵ Established an Innovation Fund which supported a number of projects in Victoria around the employment of people with mental illness, including the development of social firms.²⁶
2009	Fourth National Mental Health Plan	<ul style="list-style-type: none"> Social inclusion and recovery was a key focus of the plan. Commitment to ensure that: <ul style="list-style-type: none"> 'people with mental health problems and mental illness have improved outcomes in relation to housing, employment, income and overall health and are valued and supported by their communities.'²⁷
2011	2011–12 Budget Measures	<ul style="list-style-type: none"> Commitment to: <ul style="list-style-type: none"> triple the number of headspace centres across Australia from 30 to 90 centres over the next five years. fund 12 new Early Psychosis Prevention and Intervention Centres (EPPIC) to be delivered in partnership with the states and territories.²⁸ New wage subsidies to encourage more employers to recruit and retain jobseekers with barriers to employment, including mental illness. Undertook to expand the JobAccess information and advice service to include professionals in mental health who will offer information to employers and jobseekers and direction to appropriate program support. Undertook to expand the PHaMs.²⁹

25 Advisory group on inclusion of people with disability through sustainable supported employment (2012) *Advisory group: vision for sustainable supported employment*.

26 Department of Education, Employment and Workplace Relations (2009) *National mental health and disability employment strategy*. Canberra, Department of Education, Employment and Workplace Relations, Commonwealth of Australia, p.23.

27 Commonwealth of Australia (2009) *Fourth national mental health plan: An agenda for collaborative government action in mental health 2009-2014*. Canberra, Commonwealth of Australia, p.iv.

28 Prime Minister, Minister for Health and Ageing, & Minister for Mental Health and Ageing, Commonwealth of Australia, *2011-12 Budget offers greater support for mental health patients*, Media release, 25 October 2011.

29 Department of Education, Department of Health and Ageing, & Department of Families, Housing, Community Services and Indigenous Affairs (2011) *Response to the inquiry into mental health and workforce participation*, pp.35, 39.

Year	Policy Response	Details
2011	House of Representatives Inquiry into Mental Health and Workforce Participation	<ul style="list-style-type: none"> Established to examine barriers to participation in education, training and employment of people with mental illness and to develop recommendations related to: ways to improve collaboration between government, health, community, education, training, employment and other services strategies to improve the capacity of individuals, families, community members, coworkers and employers to respond to the needs of people with mental illness.

Source: Compiled by Family and Community Development Committee.

3.2.2 Victorian Government responsibilities

The Committee identified that the Victorian Government has responsibility to influence the incentives for and barriers to workforce participation experienced by people with mental illness.

Mental health

Inquiry participants indicated their support for state-funded mental health services to increase their involvement in assisting workforce participation by people with mental illness. The suggestion was made that services could promote employment as an important option for client recovery goals in all treatment, care and rehabilitation plans.³⁰ This issue is considered further in Chapter 8, which outlines an expanded role for mental health services in supporting patients' vocational rehabilitation.

In 2009–10, around 59,000 people with severe mental illness received clinical care from specialist mental health services funded by the Victorian Government.³¹ Around 14,000 people each year also receive social support services from community managed mental health services funded by the Victorian Government.³²

The Victorian Government currently spends approximately \$93m each year—or approximately ten per cent of the State's annual mental health budget—on PDRSS.³³ Table 3.4 outlines Victoria's public mental health system.

30 *Submission 42*, Dr Geoff Waghorn—Queensland Centre for Mental Health Research, p.6.

31 Steering Committee for the Review of Government Service Provision (2012) *Report on government services 2012*, Table 12A.28.

32 Department of Health (2012) *Psychiatric Disability Rehabilitation and Support Services reform framework: Consultation paper*, p.8.

33 Department of Health (2012) *Psychiatric Disability Rehabilitation and Support Services reform framework: Consultation paper*, p.8. This is based on total Victorian Government recurrent expenditure on mental health of almost \$907 million for the year 2009–10. See Steering Committee for the Review of Government Service Provision (2012) *Report on government services 2012*, Table 12A.2.

Table 3.4: Victoria's public mental health system

Type of service	Services and programs delivered
Area Mental Health Services (AMHS)	<ul style="list-style-type: none"> Specialist clinical mental health services organised along geographical lines. 21 AMHS across the State provide bed-based as well as community-based assessment, diagnosis, treatment, rehabilitation and clinical case management.³⁴ Organised into separate service streams for children and adolescents, adults, and those aged 65 and over.
Specialist and statewide services	<ul style="list-style-type: none"> Support AMHS through developing and disseminating best practice models for the identification and treatment of particular forms of mental illness. Some services deliver targeted clinical care to particular population groups with complex needs such as people with dual disability. Includes the Early Psychosis Prevention and Intervention Centre (EPPIC) service operated by Orygen Youth Health to address the needs of people aged 15–24 with first episode psychosis in western and north-western Melbourne.
Psychiatric Disability Rehabilitation and Support Services (PDRSS)	<ul style="list-style-type: none"> Non-clinical support services delivered through a variety of community managed organisations including stand-alone mental health services, community health services and community welfare services. Aim to 'make it easier for people with a mental illness to live well in the community, to enjoy a high quality of life and to fulfil their potential.'³⁵ Programs include residential rehabilitation programs, day programs, planned respite, mutual self-help programs, and home-based outreach support services.³⁶ Some PDRSS providers also deliver Commonwealth-funded Disability Employment Services (DES). Several providers have established social firms—businesses that trade to provide employment to disadvantaged job seekers—to provide clients with pathways into employment.

Source: Compiled by Family and Community Development Committee.

Equal opportunity and antidiscrimination legislation

Discrimination against people in employment because of mental illness, whether direct or indirect, is unlawful under several pieces of Commonwealth and Victorian legislation. The *Equal Opportunity Act 2010* (Vic) (EO Act) has robust provisions concerning the prevention of discrimination against people with mental illness in employment. Table 3.5 outlines Commonwealth and Victorian legislation.

34 Department of Human Services (2006) *An introduction to Victoria's specialist clinical mental health services*. Melbourne, Mental Health Branch, Department of Human Services, State of Victoria, p.13.

35 Psychiatric Disability Services of Victoria (VICSERV) (2010) *Community-managed mental health in Victoria: The case for investment*. Melbourne, Psychiatric Disability Services of Victoria (VICSERV), p.9.

36 Department of Health (2012) *Psychiatric Disability Rehabilitation and Support Services reform framework: Consultation paper*, p.8.

Table 3.5: Legislation prohibiting employment discrimination

Act	Details
<i>Disability Discrimination Act 1992</i> (Commonwealth)	<ul style="list-style-type: none"> • Defines disability to include mental illness, whether temporary or permanent; past, present or future; actual or impaired. • Under Section 15, it is unlawful for employers or those acting on their behalf to discriminate against a person on the grounds of disability in: <ul style="list-style-type: none"> • determining who should be offered employment or the terms or conditions on which employment is offered • denying or limiting access to opportunities for promotion, transfer or training, or to any other benefits associated with employment • dismissing the employee or subjecting the employee to any other detriment.
<i>Fair Work Act 2009</i> (Commonwealth)	<ul style="list-style-type: none"> • Section 351 prohibits an employer from taking adverse action against an employee or prospective employee because of a protected characteristic (including mental illness). • Adverse action can include dismissal, injuring the employee, altering the position of the employee to the employee's prejudice, refusing to employ a prospective employee or discriminating against an employee.³⁷
<i>Equal Opportunity Act 2010</i> (Vic)	<ul style="list-style-type: none"> • Came into effect in August 2011. • Sections 16 and 18 prohibit discrimination against job applicants and existing employees on grounds of mental illness (among other protected characteristics). • Section 15 imposes a positive duty on organisations 'to take reasonable and proportionate measures to prevent and eliminate discrimination.'³⁸ • Section 20 requires employers to make reasonable adjustments for persons offered employment or existing employees who require adjustments in order to perform the genuine and reasonable requirements of the employment.

Source: Compiled by Family and Community Development Committee.

The Committee heard that equal opportunity and anti-discrimination legislation are key drivers for influencing the attitudes of employers in the context of employees with mental illness. Associate Professor Anthony LaMontagne from the VicHealth Centre for the Promotion of Mental Health and Community Wellbeing (McCaughey Centre) told the Committee that concerns about employers' obligations under equal opportunity and antidiscrimination legislation have been a significant factor in motivating businesses to undertake mental health literacy training:

Many employers are rightly concerned that if they say the wrong thing to someone they think might have a mental illness, they could end up in court ... That is where programs like *beyondblue*, Mental Health First Aid and so on help people actually negotiate the web of regulatory demands like OHS [occupational health and safety], anti-discrimination, equal opportunity and labour law.³⁹

37 Australian Human Rights Commission (2010) *Workers with mental Illness: A practical guide for managers*. Sydney, Australian Human Rights Commission, p.34.

38 *Submission 41*, Victorian Equal Opportunity and Human Rights Commission, p.2.

39 *Transcript of evidence 24*, Associate Professor Anthony LaMontagne—VicHealth Centre for the Promotion of Mental Health and Community Wellbeing (McCaughey Centre), 7 March 2012, p.7.

Occupational health and safety

In Victoria, occupational health and safety legislation is important in instructing employers to provide mentally healthy workplaces.

While participation in employment is generally considered positive for people's mental health, some workplace behaviours and working conditions can pose risks to mental health. The most common of these are bullying, harassment and work stress.

Under Section 21 of the *Occupational Health & Safety Act 2004* (Vic) (OHS Act), employers in Victoria are required to:

so far as is reasonably practicable, provide and maintain for employees ... a working environment that is safe and without risks to health.⁴⁰

Section 5 stipulates that health 'includes psychological health.'⁴¹

The Committee received evidence that injury claims related to mental health issues caused by work are increasing in Victoria.⁴² WorkSafe told the Committee that this is an area of concern because it is harder to assist workers with mental health related injuries to return to work.⁴³

The Committee determined that eliminating work risks to mental health through fostering mentally healthy workplaces is critical in preventing early exits from work, reducing work absences and increasing the productivity of those in employment.⁴⁴ This issue is discussed in detail in Chapter 7.

Education and training

As outlined in Chapter 1, many people with mental illness experience their first symptoms between the ages of 16 and 25. The onset of mental illness during this period can disrupt people's engagement in school and hinder their transition to further education and training. Inquiry participants suggested that assisting people to remain in school and transition to further education and training is critical to fostering workforce participation by people with mental illness. For example, Professor Eoin Killackey from Orygen Youth Health (OYH) suggested to the Committee that 'an intervention which ... got people to finish high school' would be among the most effective ways that the Victorian Government could support workforce participation of people with mental illness.⁴⁵

The Victorian Government has a key role in the provision of education and training, including the capacity to influence education outcomes among people with mental illness.

The Victorian Government leads policy development on primary and secondary education and administers Victorian Government schools. Through the Victorian Training Guarantee, the Victorian Government is also a major funder of Vocational Education and Training (VET), including trades and technical training, and regulates standards within the sector.

⁴⁰ *Occupational Health and Safety Act 2004* (VIC) s 21(1).

⁴¹ *Occupational Health and Safety Act 2004* (VIC) s 5.

⁴² *Transcript of evidence 27*, WorkSafe Victoria, 21 March 2012, p.5.

⁴³ *Transcript of evidence 27*, WorkSafe Victoria, p.5.

⁴⁴ Organisation for Economic Co-operation and Development (OECD) (2012) *Sick on the job? Myths and realities about mental health and work*. OECD Publishing, p.208.

⁴⁵ *Transcript of evidence 13*, Orygen Youth Health, 28 February 2012, p.5.

The Department of Education and Early Childhood Development (DEECD) informed the Committee that around 550,000 students undertake government funded training each year in Victoria. This includes approximately 8,800 students who self-identify as having mental illness at the time of enrolment.⁴⁶

VET is delivered through public Technical and Further Education (TAFE) institutes and private providers, including adult and community education (ACE) providers. The focus is on providing students with knowledge and skills to compete for jobs and to upgrade work skills.⁴⁷ In this respect, ensuring adequate vocational and training assistance can be particularly important in enabling people with mental illness to transition to work.⁴⁸ This is further discussed in Chapter 4.

Employment programs and social enterprise

The Commonwealth Government has principal responsibility for employment support services. The Victorian Government's role is less systematic and generally involves supporting the development of social enterprises (that is, businesses that trade to fulfil a social mission or purpose). In the past, this has been through directly funding organisations to establish social enterprises in neighbourhood renewal areas. The Department of Human Services (DHS) has also fostered social enterprise development using social procurement under its Public Housing Tenant Employment Program. Chapter 6 considers the role of social procurement in supporting workforce participation by people with mental illness in more detail.

The Victorian Government currently supports social enterprise development through its funding of Social Traders. Social Traders is an intermediary organisation that was established in 2008 with joint government and philanthropic funding to build the capacity of the social enterprise sector.

In addition to encouraging social enterprise development, the Victorian Government also funds some youth employment programs through the Department of Business and Innovation (DBI). From July 2011 to July 2013, seven youth projects are being funded by DBI to deliver employment outcomes for disadvantaged young people. DBI informed the Committee that several of these projects include a focus on assisting young people with disability or mental illness to gain sustainable employment.⁴⁹

Victorian Government policy responses

The Victorian Government has sought to foster workforce participation by people with mental illness in several ways, including:

- encouraging social enterprise development
- funding local and regional partnerships between employment service providers, community services, employers, and local government to match jobseekers with mental illness with labour shortages

46 *Transcript of evidence 29*, Department of Education and Early Childhood Development, 30 April 2012, pp.8-9.

47 Essential Services Commission (2011) *VET fee and funding review—Volume II: Technical analysis*. Melbourne, Essential Services Commission, pp.5-6.

48 *Submission 41*, Victorian Equal Opportunity and Human Rights Commission, p.5.

49 Letter from Mr Justin Hanney, Deputy Secretary, Trade and Industry Development, Department of Business and Innovation, to Chair, Victorian Parliament Family and Community Development Committee, 26 June 2012, pp.2-3.

- increasing specialist mental health services' focus on identifying and supporting patients' employment goals.

Table 3.6 details the Victorian Government's policies and related initiatives to address workforce participation by people with mental illness.

Table 3.6: Victorian Government initiatives to foster workforce participation by people with mental illness from 2005 to 2013.

Year	Policy	Details
2005– 2007	Community Enterprise Development Strategy	<ul style="list-style-type: none"> • The Victorian Government directly funded the development of 13 social enterprises employing people with mental illness or disability. • Nine of these enterprises are still operating.⁵⁰
2008	Working Victoria, Victoria's Workforce Participation Strategy	<ul style="list-style-type: none"> • <i>Victoria works for jobseekers with employment challenges</i> was a key component of the strategy.⁵¹ • It included people with mental illness as a target group.
2009	The Victorian Mental Health Reform Strategy 2009–2019	<ul style="list-style-type: none"> • The Strategy outlined a vision in which 'people with enduring mental illness are supported to participate in the community and the workforce as fully as they aspire to, without stigma or discrimination.'⁵² • The strategy envisaged a role for mental health services in achieving vocational goals and improving linkages across services.⁵³
2010	Ministerial Advisory Committee Subcommittee on Mental Health and Workforce Participation	<ul style="list-style-type: none"> • Advised the Minister for Mental Health on practical strategies to improve workforce participation by people with mental illness that could be implemented through the specialist mental health system.
2011	2011–12 Budget Measures	<ul style="list-style-type: none"> • The Victorian Government announced funding to trial four education and employment officers in two selected Area Mental Health Services (AMHS) and improve participation through awards and a research initiative.

50 Letter from Mr Paul Smith, Executive Director of Community Development, Department of Planning and Community Development, to Chair, Victorian Parliament Family and Community Development Committee, 27 April 2012, p.3.

51 Department of Innovation, Industry and Regional Development (2009) *Victoriaworks for jobseekers with employment challenges*. Melbourne, Department of Innovation, Industry and Regional Development, State of Victoria, p.4.

52 Department of Human Services (2009) *Because mental health matters: Victorian mental health reform strategy 2009-2019*, p.21.

53 Department of Human Services (2009) *Because mental health matters: Victorian mental health reform strategy 2009-2019*, pp.108-09.

Year	Policy	Details
2011–2013	Youth Projects	<ul style="list-style-type: none"> The Department of Business and Innovation currently funds seven Youth Projects to deliver employment outcomes for disadvantaged young people, including people with disability or mental illness.⁵⁴
2012	Review of Psychiatric Disability and Rehabilitation Support Services (PDRSS)	<ul style="list-style-type: none"> In April, the Victorian Government released a consultation paper outlining a framework for reform for the PDRSS sector. The Victorian Government is considering refocusing the role of PDRSS to provide ‘more direct and explicit support for social and economic participation to better support people in their recovery journey.’⁵⁵

Source: Compiled by Family and Community Development Committee.

3.3 The way forward

The Committee concluded that improving workforce participation of people with mental illness requires a broad, whole of government, policy response from the Victorian Government. It determined that the development of a mental health employment strategy would assist the Victorian Government in outlining how it will achieve its goal to increase workforce participation rates of people with mental illness in Victoria.

The Committee identified that Victorian Government policy on workforce participation by people with mental illness has concentrated on responding to the needs of those living with severe and enduring mental illness, and on intervening in specialist mental health services to improve linkages with employment support services.

3.3.1 The importance of supporting employers and intervening early

The Committee identified a need for increased focus on supporting employers to recruit and retain people with mental illness. It identified that attention needs to focus on addressing barriers experienced by employers in recruiting and retaining workers with mental illness. These barriers include:

- negative attitudes towards mental illness in the workplace
- limited understanding of how to manage mental health issues within the workplace or awareness of support services that can assist in recruiting and retaining employees with mental illness.

As discussed in Chapter 5, public understanding and awareness of depression has improved considerably over the past decade. Nevertheless, negative perceptions

54 Letter from Mr Justin Hanney, Deputy Secretary, Trade and Industry Development, Department of Business and Innovation, to Chair, Victorian Parliament Family and Community Development Committee, 26 June 2012.

55 Department of Health (2012) *Psychiatric Disability Rehabilitation and Support Services reform framework: Consultation paper*, p.19.

of people with mental illness and their capacity to work are still widespread.⁵⁶ The Committee heard that people with mental illness are frequently discriminated against in employment. Stigma leads to perceptions that people with mental illness are less reliable and less productive than other workers.⁵⁷

Participants told the Committee that employers are often reluctant to recruit someone with mental illness because they do not have the appropriate training or management skills to accommodate people with mental illness within the workplace.⁵⁸ Many employers find negotiating workplace adjustments difficult and confusing. This issue is discussed in Chapter 6.

The Committee heard that improving access to specialist employment services was unlikely to significantly increase workforce participation by people with mental illness without these barriers to participation also being addressed. For example, the Senior Manager of Research and Policy at the BSL, Mr Michael Horn, told the Committee that:

Too little focus is placed on addressing demand-side barriers in particular, including entry-level jobs, discrimination in the labour market and a lack of awareness of employers about how they can benefit from taking on this cohort of job seekers.⁵⁹

The Committee identified the benefit of a preventative approach in responding to workforce participation by people with mental illness. In particular:

- supporting young people with emerging mental health problems to remain engaged in education and learning (discussed in Chapter 4)
- preventing early exits from work through promoting healthy and supportive workplaces (discussed in Chapter 7).

The importance of early intervention and prevention in fostering workforce participation by people with mental illness has been outlined by the Organisation for Economic Co-operation and Development (OECD) in its report, *Sick on the job? Myths and realities about mental health and work*. The OECD report identifies that intervening when people claim disability benefits is far too late in many cases. Assistance should be provided much earlier through:

- preventing mental illness at an age when adolescents attend school
- intervening early and assertively for students who display symptoms of mental illness to prevent school drop-out
- securing good working conditions and sound management practices that avoid the development of work-related mental problems and minimise the productivity losses of workers caused by such problems

56 Department of Education, Employment and Workplace Relations (2008) *Employer attitudes towards employing people with mental illness*. Canberra, Department of Education, Employment and Workplace Relations, Commonwealth of Australia, p.17. See also *Transcript of evidence 9*, Australian Human Resources Institute (AHRI), 21 November 2011, pp.2-3.

57 *Transcript of evidence 10*, Victorian Equal Opportunity and Human Rights Commission, p.3.

58 *Transcript of evidence 3*, Geelong and Region Trades Hall and Labour Council, 4 November 2011, p.7.

59 *Transcript of evidence 14*, Brotherhood of St Laurence, p.2.

- helping employers avoid unnecessary dismissal caused by mental illness through the provision of adequate incentives, information and support.⁶⁰

The Committee acknowledges that measures are being implemented in schools to promote students' emotional wellbeing and to support students at risk of disengaging from learning to remain in education.⁶¹ The Committee identified, however, that schools do not always have the capacity to identify and respond to students with emerging mental health problems.⁶²

The Committee determined that the Victorian Government should increase its focus on responding to the barriers to participation experienced across the full spectrum of mental illness. This means addressing barriers to participation experienced by people with higher-prevalence mental illness such as anxiety and depression in addition to supporting clients of public mental health services to gain and retain employment.

Clients of the public specialist mental health system represent only a small proportion of the many Victorians whose participation in employment is affected by mental illness. A far greater number of Victorians experience difficulties in employment because of higher-prevalence mental illness such as anxiety and depression.⁶³ These forms of mental illness affect large numbers of people in the community and also impact significantly on productivity costs associated with mental illness. This is highlighted by the OECD in its report on mental health and work. The report calls for a greater policy focus on people with higherprevalence mental illness, stating that:

Because of its high prevalence, the overall cost of CMD [common mental disorders] to society is larger than the cost of SMD [severe mental disorders]—taking into account all the costs for the health system, the social security system and the employers ... This is explained by the fact that direct health-system costs are only a very small part of the total costs of mental illness, much lower than, in particular, the costs of productivity losses ... In order to deal with mental disorders more effectively greater focus should be devoted to CMD, which when becoming long-lasting or recurrent can manifest themselves in substantial impairments with negative repercussions on work functioning.⁶⁴

FINDING 3

That Victorian Government initiatives to foster workforce participation by people with mental illness have achieved some progress, but a greater focus is required on:

- Addressing obstacles to employers recruiting and retaining workers with mental illness such as attitudes towards mental illness in the workplace and workplaces' capacity to manage employees with mental illness.
- Early intervention and prevention in education and in workplaces.
- Responding to barriers to workforce participation experienced by people with higher-prevalence mental illness.

60 Organisation for Economic Co-operation and Development (OECD) (2012) *Sick on the job? Myths and realities about mental health and work*, p.208.

61 *Transcript of evidence 29*, Department of Education and Early Childhood Development, pp.4-8.

62 *Submission 29*, Mission Australia, p.19; *Transcript of evidence 13*, Orygen Youth Health, p.7.

63 *Transcript of evidence 5*, Victorian Mental Health Carers Network, 7 November 2011, p.7.

64 Organisation for Economic Co-operation and Development (OECD) (2012) *Sick on the job? Myths and realities about mental health and work*, p.202.

3.3.2 A mental health employment strategy for Victoria

The Committee identified a need for the Victorian Government to develop an overarching statewide strategic plan on workforce participation and mental illness. The strategy should outline how the Victorian Government will work with the public and private sectors to achieve its commitment of a 20 per cent increase in employment among people with mental illness by 2020.

The current Victorian Government policy responses represent steps towards achieving this target. Inquiry participants, however, expressed the need for greater action by all levels of government in responding to workforce participation by people with mental illness.

Participants pointed out that there has been extensive consultation and commissioning of research on strategies to achieve improved outcomes, yet little concrete action has resulted. The Chairman of the Victorian Mental Health Carers Network (VMHCN), Mr Colin Fryer, stated that carers:

Desperately want State and Federal Governments to take action, to take some initiatives to fund programs that are known to work [referring to co-locating employment consultants within mental health services], then come and talk to carers about what new things are being done and how they are working. There has been a lot of recent work on this topic which carers and consumers are being asked to contribute to. They wonder why another inquiry is necessary. They remember very recent work on the current federal inquiry ... the National Mental Health and Disability Employment Strategy 2009, the DEEWR [Department of Education, Employment and Workplace Relations] Literature Review of 2008, the paper Reforming Welfare to Work by the Welfare to Work Reform Collaboration, and personally, I remember it was less—well, just over a year ago that a subcommittee of the then Ministerial Advisory Committee spend a year working on this topic and submitted a very good, I believe, well-considered paper to the Minister at that time.⁶⁵

The Committee determined that a well-defined mental health employment strategy would enable the Victorian Government to outline its intended actions to address the barriers to participation experienced by people with mental illness.

The Committee identified that a mental health employment strategy would need to establish clear priorities for the next eight years and outcome measures against which progress can be tracked to facilitate transparency and accountability (see Recommendation 3.2).

In developing a mental health employment strategy for Victoria, the Committee considered that it is important that the Victorian Government work closely with relevant stakeholders such as employers, unions, the recruitment industry, and mental health organisations. In particular, the Committee determined that it is critical to involve employers and those involved in recruitment in developing and supporting policy responses to foster workforce participation by people with mental illness.

As outlined earlier, addressing obstacles to employers recruiting and retaining workers with mental illness is critical to fostering workforce participation by people with mental illness. The Chief Executive Officer of the Australian Human Resources

65 *Transcript of evidence 5*, Victorian Mental Health Carers Network, p.7.

Institute (AHRI), Mr Serge Sardo, told the Committee that while government needs to drive policy responses to workforce participation by people with mental illness:

There is a real issue here about stakeholders, champions and employer groups really getting on top of this issue ... Employers need to be made accountable for this as well as associations ... It is not just government but all the relevant bodies that need to be involved in this.⁶⁶

Chapters 5 and 6 discuss approaches that the Victorian Government can take in working with employers to change attitudes towards mental illness in the workplace, promote the benefits of employing workers with mental illness, and support workplaces in managing and responding to employees with mental illness.

Many barriers to workforce participation by people with mental illness are based in policy areas where the Commonwealth Government has primary responsibility. In view of this, the strategy will also need to specify how the Victorian Government will work with the Commonwealth Government to achieve its objectives. This is critical to avoiding program duplication and ensuring that Commonwealth and Victorian policy responses are aligned. Ms Anthea Tsismetsi, Policy and Research Officer with Psychiatric Disability Services Victoria (VICSERV), highlighted this point:

With significant crossover into Commonwealth responsibilities, it is important that a fully integrated and a coordinated approach be taken in developing an education and employment strategy for people living with a mental illness. This partnership needs to be holistic in approach and be able to influence various departments ... to ensure a fully integrated approach to meeting the needs of people with mental illness.⁶⁷

The Committee recommends that the strategy encompasses a multilayered approach targeting action across five key areas relating to:

- reducing stigma
- supporting people to return to education
- promoting healthy and supportive workplaces
- creating diverse and flexible employment opportunities
- improving linkages between mental health and employment services.

The remaining chapters of the report detail the initiatives that the Victorian Government needs to implement within these areas.

→ **RECOMMENDATION 3.2:**

That the Victorian Government develops a mental health employment strategy that outlines its forward plan to increase workforce participation by people with mental illness with the capacity to work from 29 to 50 per cent across the public and private sectors by 2020 through:

- Changing attitudes towards mental illness and the employment of people with mental illness.
- Preventing people with mental illness from leaving work and education prematurely.
- Creating diverse and flexible employment pathways for people with mental illness.
- Improving linkages between mental health and employment services.

⁶⁶ *Transcript of evidence 9*, Australian Human Resources Institute (AHRI), p.6.

⁶⁷ *Transcript of evidence 6*, Psychiatric Disability Services Victoria (VICSERV) & Eastern Regions Mental Health Association (ERMHA), 7 November 2011, p.4.

Monitoring the strategy

For the proposed mental health employment strategy to effectively address the issue of improving workforce participation by people with mental illness, the Committee considered that it should be accompanied by an implementation plan and system for monitoring progress.

The implementation plan should detail the steps the Victorian Government will take to achieve its target of 50 per cent employment among people with mental illness by 2020.

Outcome measures and indicators also need to be developed so that progress towards the goals of the mental health employment strategy can be continually tracked and reported. The Committee notes the example of the recently released *Draft Victorian state disability plan 2013–16*, which proposes tracking progress against implementation plans annually and reporting on progress in bi-annual reports. The Committee considers that a similar schedule for reporting on progress under a mental health employment strategy could be adopted by the Victorian Government.

Indicators for tracking progress against outcome measures across policy areas related to workforce participation by people with mental illness could include:

- the proportion of students with mental illness completing year 12 or equivalent
- completion and enrolment rates of students with mental illness in VET
- proportion of mental health services clients maintaining or entering employment
- workforce participation rate among people with mental illness
- the number of mental health related sickness absences and occupational injury claims.

Indicators are only effective where there is reliable data. The Committee acknowledges that this is a challenge in the context of indicators related to workforce participation by people with mental illness.

Many people with mental illness in education and employment do not disclose their mental illness to their employer or to relevant student services. As noted in Chapter 2, the Committee has concerns about the way in which workforce participation by people with mental illness is measured and reported in Australian Bureau of Statistics (ABS) surveys. Hence, careful consideration needs to be given to the quality of available data sources when developing indicators and outcome measures.

→ RECOMMENDATION 3.3:

That as part of the Strategy planning process, the Victorian Government incorporates an implementation plan and monitoring framework into the Strategy to specify how its goals will be achieved and monitor its achievement.

Governance framework

Establishing an appropriate governance framework will be critical to the successful implementation of a mental health employment strategy. The Committee identified a clear need for a central body to lead the development and implementation of a strategy aimed at fostering workforce participation among people with mental illness. This ensures accountability for the strategy.

In view of its responsibility for policy setting and service administration in relation to mental health, the Committee determined that the Department of Health (DoH), through the Minister responsible for mental health, should lead the strategy.

Fostering workforce participation by people with mental illness requires coordinated action and planning across several government departments and agencies. It also requires close collaboration with non-government stakeholders including employers, recruiters, unions, and community sector organisations involved in delivering employment support, training, and mental health services to people with mental illness.

To reflect the cross-sectoral policy response required, the Committee considers that the DoH needs to coordinate closely with other government departments and agencies and non-government stakeholders in developing and implementing a mental health employment strategy.

→ **RECOMMENDATION 3.4:**

That the Minister responsible for mental health takes the lead in overseeing the development, implementation and coordination of a mental health employment strategy, working closely with other government departments and stakeholders.

Chapter Four: Ensuring opportunities in education

Findings

1. That helping people with mental illness to stay engaged in education and vocational training is critical to fostering workforce participation for people with mental illness, particularly in a labour market requiring higher skill levels and qualifications.
2. That early identification, intervention and treatment can help young people with mental illness remain engaged in education and go on to further education and employment.
3. That school mental health promotion programs should have a sharper focus on building mental health literacy and countering stigma in order to encourage students experiencing mental health issues to seek help early and remain engaged in education.
4. That countering stigma among young people in higher education and vocational training is also critical to encouraging students enrolled in university and TAFE to seek help early for mental health issues.
5. That staff within schools require assistance such as training in Mental Health First Aid to identify students at risk of disengaging from education because of mental illness.
6. That Disability Liaison Officers may not provide adequate support for people with mental illness due to a focus on physical disability.
7. That people with mental illness who are disengaged from education can have complex needs and may require tailored support to assist them to return to education and training.
8. That participants identified programs such as Victorian Certificate of Applied Learning (VCAL) and training courses offered by TAFEs as good concrete examples of providing alternative and flexible education and training pathways, with many success stories.
9. That flexible learning options and intensive support provided through Community VCAL programs may enable people with mental illness to re-engage in senior secondary education.
10. That greater flexibility within VET courses including use of information technology and tailored timetabling can assist students with mental illness to remain engaged in training and education.
11. That diverse approaches are needed to assist people with mental illness to return to education and training. Supported return-to-learning pathways must co-exist with appropriately tailored mainstream pathways.
12. That there needs to be improved understanding of how tailored education programs can assist people with mental illness to effectively re-engage in education and training.

During the Inquiry, the Committee heard that people who experience mental illness early in life face significant educational barriers that can lead to difficulties in employment. Inquiry participants commented that the onset of mental illness in youth can ‘derail a young person from attaining critical educational and career benchmarks that are so crucial to the rest of their lives.’¹

The Committee identified the need to intervene early to assist young people who experience mental illness to complete their education. There are a number of initiatives to promote mental health within schools and to support young people with mental health issues to remain engaged in education. However, the Committee determined that much more needs to be done in schools, Technical and Further Education (TAFE) institutes, and universities to detect early signs of mental illness and to respond to the needs of students with emerging mental health issues. In particular, the Committee identified a need to provide greater support and expertise to educators.

The Committee also examined current pathways available to people with mental illness to re-engage in education and training opportunities, and the key role of Victoria’s vocational education and training (VET) system. It also identified the need for more research into innovative supported learning settings and services to help people re-engage in mainstream education settings.

4.1 The importance of ensuring education opportunities

Evidence shows that education is a critical factor in determining employment outcomes. Studies consistently show that levels of educational attainment are closely related to whether people participate in the workforce and the type of jobs and earnings that people can obtain, as described in Box 4.1.

1 *Submission 18, Orygen Youth Health, p.3.*

Box 4.1: Relationship between education and unemployment

In May 2010, the unemployment rate was almost 10 per cent among people who left school following year 10 compared with an unemployment rate of 6.4 per cent among those who completed year 12.² By contrast, the unemployment rate among those who had completed a Certificate III/IV level VET qualification was less than 4 per cent.

Research carried out by Ernst & Young and the Inspire Foundation shows individuals in Australia who have a degree or higher qualification earn wages 30 to 45 per cent higher than those who have not completed year 12.³

Employment growth over the past 20 years has been strongest in jobs that require post-secondary qualifications. Between 1995 and 2005, the number of Australian workers with post-secondary qualifications increased by 44.7 per cent compared with overall employment growth of less than 20 per cent. If this trend continues, it is expected that more than 71 per cent of the employed workforce will have some post-school qualification by 2016.⁴ It is also anticipated that half of the projected employment growth over the next four years will be in occupations that require at least a diploma level qualification.⁵

Source: Compiled by Family and Community Development Committee.

4.1.1 Low levels of educational attainment among people with mental illness

The onset of mental illness in youth can have an enormous impact on young people's ability to effectively participate and sustain their involvement in education.

Symptoms associated with mental illness can directly impair faculties that are critical to educational achievement, such as 'concentration, ability to organise, plan and process information.'⁶ Attending classes that start early in the morning can also be difficult for those taking medications that cause side effects such as disrupted sleep patterns. Students can miss classes and fall behind in their coursework, especially as young people are often reluctant to disclose mental illness to teachers or support staff due to stigma.

Consequently, as Ms Laura Collister, General Manager of Rehabilitation Services, Mental Illness Fellowship of Victoria (MI Fellowship), told the Committee:

People do not finish their year 12, or if they do finish their year 12 their performance is compromised. They may go on to university or may not and they drop out, but they fail to get that basic education that is going to set them up for the future.⁷

Data shows that young people who experience mental illness are less likely to have completed school, higher education, or vocational education and training than their peers. According to the Australian Bureau of Statistics (ABS) 2007 *National survey of*

2 Data reported in Australian Bureau of Statistics (2010) *Education and work, Australia, May 2010* (Catalogue no. 6227.0). Canberra, Australian Bureau of Statistics.

3 Degney, J., Hopkins, B., Hosie, A. et al. (2012) *Counting the cost: The impact of young men's mental health on the Australian economy*. Inspire Foundation and Ernst & Young, p.36.

4 Shah, C. & Burke, G. (2006) *Qualifications and the future labour market in Australia*. Melbourne, Monash University—ACER Centre for the Economics of Education and Training, pp.xi-xii.

5 Department of Education, Employment and Workplace Relations (2011) *Australian jobs 2011*. Canberra, Department of Education, Employment and Workplace Relations, Commonwealth of Australia, p.25.

6 Alfred CAMHS & Avenues Education (2010) *Stronger futures for all young Victorians: response to discussion paper on Youth Transitions*. Melbourne, The Alfred and Avenues Education, p.4.

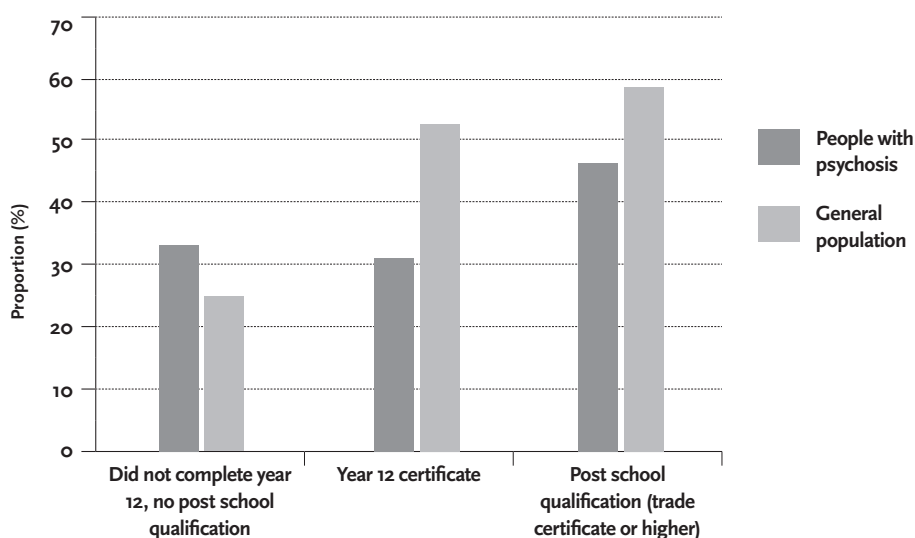
7 *Transcript of evidence 25*, Mental Illness Fellowship of Victoria, 7 March 2012, p.3.

mental health and wellbeing, people with mood and anxiety disorders are less likely to have attained a post-secondary qualification, particularly a Bachelor's degree or higher, than people with no mental illness.

The disparity in education is even more pronounced for people with severe mental illness such as psychosis. For example, Orygen Youth Health (OYH) reported that a young person who has experienced psychosis 'is almost three times less likely to have completed secondary school than their peers ...'⁸ Professor Eoin Killackey told the Committee that more than half of the clients of OYH's early psychosis service leave school before completing year 10, while 10 to 15 per cent leave at year 7.⁹

As shown in Figure 4.1, the *People living with psychotic illness 2010* study found that only a third of participants who had experienced psychosis had completed year 12 or its equivalent. This compared with more than half of the general population.¹⁰ The study also found that people with psychosis had significantly poorer post-secondary educational outcomes, including vocational training, than people with no mental illness.

Figure 4.1: Educational attainment among people with psychosis compared with the general population



Source: Morgan, V. A., Watterreus, A., Jablensky, A. et al. (2011) *People living with psychotic illness 2010*, report for the Department of Health and Ageing, Commonwealth of Australia, p.3.

Inquiry participants told the Committee that the low level of educational and vocational qualifications among people with mental illness is a major barrier to employment.¹¹

The Committee heard that as the importance of educational attainment increases in the work context, gaining qualifications and training will become increasingly

⁸ Submission 18, Orygen Youth Health, p.3.

⁹ Transcript of evidence 13, Orygen Youth Health, 28 February 2012, p.5.

¹⁰ Morgan, A.J., Watterreus, A., Jablensky, A. et al. (2011) *People living with psychotic illness 2010*, report for the Department of Health and Ageing, Commonwealth of Australia, p.3.

¹¹ See for example Submission 18, Orygen Youth Health, p.8; Submission 23, Pathways Rehabilitation and Support Services & Barwon Health, pp.6-7; Transcript of evidence 25, Mental Illness Fellowship of Victoria, p.4.

important in facilitating workforce participation by people with mental illness. As OYH stated in its submission:

As the employment market requires greater degrees of qualification and training, not finishing high school or its equivalent, or not finishing post-secondary training places the individual with a mental illness at a competitive disadvantage in the employment market. It condemns them to only being able to fill low paid jobs. Where the wages and social status of such jobs are on a par with the benefits and pensions that people with mental illness may be otherwise qualified for and able to access, there will be little incentive to pursue employment.¹²

The Committee identified that mental health promotion programs, early identification of mental health issues, support services and pathways to re-engage with education are critical in order to maximise employment opportunities for people with mental illness.

FINDING 1

That helping people with mental illness to stay engaged in education and vocational training is critical to fostering workforce participation for people with mental illness, particularly in a labour market requiring higher skill levels and qualifications.

4.2 Mental health promotion in educational settings

Inquiry participants highlighted that mental health promotion programs in educational settings are important in preventing people from disengaging from learning due to mental health issues.

The importance of mental health promotion has been recognised in the *Victorian mental health reform strategy*. The Strategy states ‘childhood and youth is a critical time for laying the foundation for mental health’ and recognises that ‘schools and early childhood settings play an important role in influencing mental wellbeing.’¹³

The Committee identified a number of Commonwealth and Victorian Government health promotion programs operating in Victorian schools, as outlined in Table 4.1. These programs aim to prevent the emergence of mental health issues by strengthening resilience in students and fostering learning environments that promote students’ emotional wellbeing.

12 Submission 18, Orygen Youth Health, p.8. See also *Transcript of evidence 25*, Mental Illness Fellowship of Victoria, p.4.

13 Department of Human Services (2009) *Because mental health matters: Victorian mental health reform strategy 2009-2019*. Melbourne, Mental Health and Drugs Division, Department of Human Services, State of Victoria, p.69.

Table 4.1: Mental health promotion programs in schools

Lead government	Program	Target group	Overview
Commonwealth Government	MindMatters	Secondary students	<ul style="list-style-type: none"> Resource and professional development program. Encourages promotion, prevention and early intervention activities in mental health. As at July 2009, 82 per cent of secondary schools had participated in MindMatters.¹⁴
Commonwealth Government	KidsMatter	Early childhood services and primary schools	<ul style="list-style-type: none"> Resource and professional development program complementing MindMatters. KidsMatter was originally trialled in over 100 primary schools across Australia, including 20 primary schools in Victoria.¹⁵ In 2010–11, the Commonwealth Government provided funding to extend the rollout the program.¹⁶
Victorian Government	The Victorian Prevention and Health Promotion Achievement Program ¹⁷	Schools and early childhood education and care services	<ul style="list-style-type: none"> Program to support compliance with state-wide benchmarks for health promotion. Mental health and wellbeing one of eight priority areas identified.
Victorian Government	Promoting Healthy Minds for Living and Learning ¹⁸	Schools and early childhood settings	<ul style="list-style-type: none"> Information resource for staff to encourage: <ul style="list-style-type: none"> Safe, inclusive and empowering learning environments Social and emotional learning Family, community and service partnerships.

Source: Compiled by Family and Community Development Committee.

14 Education and Training Committee (2010) *Inquiry into the potential for developing opportunities for schools to become a focus for promoting healthy community living*. Melbourne, Parliament of Victoria, p.54.

15 The 20 primary schools in Victoria that participated in the KidsMatter pilot were: Christ the King Primary School, Hastings Primary School, Monmia Primary School, Sacred Heart Primary School, Saint Joseph's, St. Bernadette's Primary School, St Christopher's School, St. Vincent de Paul Primary School, Tootgarook Primary School, Upper Ferntree Gull Primary School, St. Mary's Primary School, Benalla Primary School, Corio Primary School, Lumen Christi, North Brunswick Primary School, Southvale Primary School, St. Andrew's Primary School, St. Therese's Primary School, and St. Louis De Montfort Primary.

16 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*. Canberra, Parliament of the Commonwealth of Australia, p.49.

17 Department of Health (2011) *Victorian prevention and health promotion achievement program for schools and early childhood education and care services: consultation paper*. Melbourne, Prevention and Population Health Branch, Department of Health, State of Victoria, p.3.

18 *Transcript of evidence 29*, Department of Education and Early Childhood Development, 30 April 2012, p.4.

The Committee considered that while the inclusion of mental health promotion programs in Victorian schools is positive, there is a need for improvement in the following areas:

- Early identification of mental health issues (discussed in Section 4.3).
- Careful monitoring and evaluation of programs to ensure they achieve effective outcomes. The Committee considered that the *Victorian attitudes to school survey* (described in Box 4.2) could be a potential vehicle for evaluating the effectiveness of mental health promotion programs.

Box 4.2 The Victorian attitudes to school survey

Since 2006, the *Victorian attitudes to school survey* has been administered to government school students in years 5–12 to collect information about student engagement with learning. The survey includes questions about students' motivation, willingness to learn, personal aspirations, and learning confidence. It also captures information about emotional factors that affect students' engagement with learning, including:

- Student morale—this measures positive emotions such as being cheerful, relaxed and happy.
- Student distress—this measures negative emotions such as being tense, frustrated, depressed, uneasy and stressed at school.
- Student connectedness—this measures how students' feel about school.

According to *The state of Victoria's children 2010* report, students' connectedness to school has been progressively improving since 2006 across all year levels of secondary school. Student moral has also been increasing each year while levels of distress among students have been decreasing at a similar rate.

Source: Department of Education and Early Childhood Development (DEECD) (2011) *The state of Victoria's children 2010*. Melbourne, Communications Division for Data, Outcomes and Evaluation Division, DEECD, State of Victoria, pp. 187-192.

→ RECOMMENDATION 4.1:

That the Victorian Government establishes a strategy to monitor and evaluate the implementation of mental health promotion programs in schools.

4.3 Early identification of mental health issues

The Committee heard that early identification and intervention of mental illness in young people is critical to enabling successful transitions to employment.¹⁹

Research shows that the costs of failing to identify mental health concerns in young people are high and on the increase:

- ‘On average, one Victorian student attempts suicide each week of the school year.’²⁰
- There has been an increase in the rate of students threatening to commit suicide or self-harming.²¹
- The past decade has seen a significant rise in the self-harming hospital admission rate for young people aged 12–17 years.²²

Despite these rising costs, evidence shows that only about one in four young people who experience mental health problems receive professional help—and only half of those with the most severe problems.²³

Inquiry participants told the Committee that students with emerging mental health problems can ‘fall through the cracks’ in the education system because they are too frequently dismissed as ‘problem’ students.²⁴ In material presented to the Committee, the Brotherhood of St Laurence (BSL) stated that:

Learning difficulties and antisocial behaviour at school may signal the onset of serious mental illness. Yet too many schools lack the resources to respond appropriately—rather they rely on ‘managing’ these students through suspensions, unplanned departures or transfers.²⁵

Failure to identify mental illness early and refer students to appropriate health services can have far reaching effects on a person’s life, as illustrated by the example provided in Box 4.3.

19 For example, see *Transcript of evidence 25*, Mental Illness Fellowship of Victoria, pp.6-7.

20 Barry, E. ‘Shocked education minister orders probe into student suicides, mental health issue among teens’, *Herald Sun*, 12 December 2011.

21 Barry (2011) ‘Shocked education minister orders probe into student suicides, mental health issue among teens’.

22 Department of Education and Early Childhood Development (2010) *The state of Victoria’s children 2010*. Melbourne, Communications Division for Data, Outcomes and Evaluation Division, Department of Education and Early Childhood Development, State of Victoria, p.108.

23 Department of Human Services (2009) *Because mental health matters: Victorian mental health reform strategy 2009-2019*, p.37.

24 See, for example, *Submission 29*, Mission Australia, p.4.

25 *Supplementary evidence 14A*, Brotherhood of St Laurence, 28 February 2012, p.16.

Box 4.3 Example of failure to identify mental illness

Professor Killackey gave the example of a client of Orygen's Early Psychosis Prevention and Intervention Centre (EPPIC) service who is now in his 30s and has never worked. This client was a high-achieving student when he experienced his first symptoms. However, because his symptoms were not picked up, his mental illness went untreated placing him on a trajectory towards unemployment:

He got into uni but dropped out after a year and a half. He was smoking more and drinking more because there was a lot going on in his head that he was trying, I think, to medicate. He was kicked out of home by his family, and it was a long time before his illness was picked up. But the point is that if when he was 16 years somebody had thought that there might have been something going on for this young man, a very different trajectory could have resulted from it. He had not fallen out of school at that point. He was obviously able to pass year 12 even with what was going on. There is every reason to believe that he would not now be someone [who] has never worked in his life.²⁶

Source: Compiled by Family and Community Development Committee.

Inquiry participants commented that schools and other educational institutions have a critical role to play in facilitating such early identification and intervention. They acknowledged some progress in implementing programs within schools to facilitate early identification of mental illness among students. However, there was a view among some participants that existing programs are not coordinated in their approach. For example, Professor Killackey from OYH told the Committee that:

In terms of mental illness and identifying it early, there are all sorts of programs that are probably doing this in a sort of haphazard way. Obviously the key place where young people are is school. Maybe it is even in the training of teachers, to make them much more aware for early signs of mental illness. I think particularly for young men—and men tend to have an earlier onset of things like psychosis than women, who tend to be a bit later—a lot of the early signs of that in the context of classrooms tend to get dismissed as bad behaviour and people get treated as the naughty kid rather than the kid who actually needs a bit of early help.²⁷

In order to improve the early identification of mental health issues, the Committee determined that there is a critical need to increase young people's awareness and understanding of mental health issues, to combat stigma and to improve student screening programs and training for educational staff. The Committee also identified that it is important that schools work closely with youth mental health services, such as headspace, so that students who display signs of emerging mental health issues receive appropriate treatment and care.

FINDING 2

That early identification, intervention and treatment can help young people with mental illness remain engaged in education and go on to further education and employment.

²⁶ Transcript of evidence 13, Orygen Youth Health, p.7.

²⁷ Transcript of evidence 13, Orygen Youth Health, p.7. See also Submission 29, Mission Australia, p.19.

4.3.1 Improving mental health literacy among students

The Committee heard that young people do not know how to identify when they have a mental health problem. For example, Ms Collister from MI Fellowship told the Committee that young people ‘do not know when to put up their hand and say, “You know what? I think something is going severely wrong here”’.²⁸ She went on to explain the benefits of improving mental health literacy amongst students:

The more literacy people have, the more education there is in the schools that creates a message that people do have mental illness, that it is treatable and that you can recover. Those sorts of messages [are] really important.²⁹

The importance of improving mental health literacy in young people is supported by research. Rickwood, Deane and Wilson, for example, suggest that:

Young people are more likely to seek help when they recognise that they have a mental health problem and have the knowledge, skills and encouragement to seek help ... Lack of recognition of mental health problems among young people and their parents is a major ‘filter’ to help-seeking. Poor mental health literacy is common among young Australians, particularly adolescent boys, and is a significant barrier to professional help-seeking.³⁰

Improving mental health literacy can also help to create peer supports around young people with mental illness. The Committee heard that young people commonly confide in friends about mental health problems. Yet many young people lack the information and skills to assist their friend to seek appropriate help. For example, Professor Anthony Jorm from the Centre for Youth Mental Health at the University of Melbourne told the Committee that when young people are asked what they would do if their friend told them they were suicidal, ‘a lot of young people would say that they would not tell anyone because it is confidential’.³¹

4.3.2 Reducing stigma in education settings

The Committee identified that stigma associated with mental illness is a major barrier to young people seeking help for mental health problems. Research shows that many young people feel embarrassed about having mental illness and fear negative reactions from the person being approached for help.³²

Associate Professor Carol Harvey from the Psychosocial Research Centre told the Committee that overcoming the barrier of the stigma of mental illness is the biggest challenge in helping young people to access the help they need to stay enrolled in education.³³

28 *Transcript of evidence 25*, Mental Illness Fellowship of Victoria, p.7.

29 *Transcript of evidence 25*, Mental Illness Fellowship of Victoria, p.7.

30 Rickwood, D.J., Deane, F.P., & Wilson, C.J. (2007) ‘When and how do young people seek help for mental health problems?’. *Medical Journal of Australia*, Vol. 187, No. 7, pp.S35-S39, p.S36. See also Kelly, C., Jorm, A.F., & Wright, A. (2007) ‘Improving mental health literacy as a strategy to facilitate early intervention for mental disorders’. *Medical Journal of Australia*, Vol. 187, No. 7, pp.S26-S30, p.S26.

31 *Transcript of evidence 28*, Centre for Youth Mental Health, University of Melbourne, 21 March 2012, p.8.

32 Jorm, A.F., Wright, A., & Morgan, A.J. (2007) ‘Where to seek help for a mental disorder? National survey of the beliefs of Australian youth and their parents’. *Medical Journal of Australia*, Vol. 187, No. 10, pp.556-60, p.558; Gulliver, A., Griffiths, K.M., & Christensen, H. (2010) ‘Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review’. *BMC Psychiatry*, Vol. 10.

33 *Transcript of evidence 17*, Psychosocial Research Centre, 28 February 2012, p.8.

The Victorian branch of the Australian Medical Association (AMA) called for Government to invest in public education campaigns to reduce the stigma associated with mental health problems and to promote good health and resilience in young people at school and the wider community.³⁴ The Committee noted the *Live4Life* program in the Macedon Ranges as an example of a successful public education campaign to reduce stigma and build resilience in young people. Box 4.4 outlines this program in detail.

Box 4.4 *Live4Life*

Live4Life is an evidenced-based mental health promotion and anti-stigma program delivered within five secondary colleges in the Macedon Ranges. It is delivered in partnership between the schools, Macedon Ranges Shire Council's Youth Development Unit and two community health services.

The program was developed in response to a reported increase from schools, police and community health organisations in the incidence of suicide, depression, cyber-bullying and self-harm among young people in the region.³⁵

The program takes an evidence-based approach to providing local schools and the community with local networks, strategies and tools to assist with mental health needs. This includes facilitating workshops, focus groups and seminars to educate students about mental illness and build resilience, as well as organising events, competitions, and student projects to raise awareness of mental illness.

Live4Life was first trialled among almost 600 year 8 students in 2010. Focusing on year 8 students allows learning to occur prior to the increase in prevalence in mental health issues at year 9 level.³⁶ The program has since been expanded to include SenseAbility mental health education training for students delivered by *beyondblue*.³⁷

SenseAbility is a strengths-based resilience program developed by *beyondblue*. It is based on cognitive-behavioural principles and is designed to enhance and maintain emotional and psychological resilience in young people.³⁸

Courses in Youth Mental Health First Aid Training for parents and carers who have students at one of the *Live4Life* schools are also offered as part of the initiative. The courses teach parents and carers about how to assist adolescents who are developing mental illness or who are in a mental health crisis.

An independent evaluation of the initiative released in January 2011 found that *Live4Life* was successful in reducing stigma in relation to mental health and sexuality issues, 'including greater awareness of professional help sources and improved attitudes towards seeking professional help if needed.'³⁹

Source: Compiled by Family and Community Development Committee.

The Committee identified that the problems associated with stigma extend to people attending TAFE and university. It heard that providing mental health support services

34 Submission 34, Australian Medical Association (AMA) Victoria, p.2.

35 Bowers, K. (2011) *Live4Life program evaluation report: February 2010—December 2010*. Live4Life, p.4. Available from <http://www.live4life.org.au/downloads/>.

36 Macedon Ranges Shire Council (2010) *Response to the inquiry into the potential for developing opportunities for schools to become a focus for promoting healthy community living*, submission to the Education and Training Committee, Parliament of Victoria, Inquiry into the potential for developing opportunities for schools to become a focus for promoting healthy community living, p.2.

37 Live4Life (2012). *Live4Life July 2012 e-newsletter*. Accessed on 20 August 2012 from <http://www.live4life.org.au/e-newsletter/>.

38 Submission 19, *beyondblue*, p.14.

39 Bowers (2011) *Live4Life program evaluation report: February 2010—December 2010*, p.33.

in these settings is severely hampered by students being unwilling to disclose mental health issues. As noted by Jennifer Martin, Associate Professor of Social Work, RMIT University, studies show that students go to ‘considerable efforts to hide their mental health condition ...’⁴⁰ Similarly, studies into VET have found that students are reluctant to disclose their mental illness partly because they fear stigma, prejudice and rejection from staff.⁴¹

Witnesses in the House of Representatives Standing Committee on Education and Employment Inquiry into mental health and workforce participation (the ‘Federal Inquiry’) similarly identified stigma as a critical barrier to people with mental illness accessing support services in universities and TAFEs.⁴² The Federal Inquiry recommended a broad community education campaign to reduce stigma. As part of this campaign, it called for involvement from the university and vocational education sectors to run education campaigns across campuses.⁴³ The Committee supports this recommendation. It considered that Disability Liaison Officers (DLOs) within universities and TAFEs could play a key role in driving an education campaign to de-stigmatise mental illness among students. The role of DLOs in supporting students with mental illness to remain engaged in education and training is further discussed in Section 4.4.2.

FINDING 3

That school mental health promotion programs should have a sharper focus on building mental health literacy and countering stigma in order to encourage students experiencing mental health issues to seek help early and remain engaged in education.

FINDING 4

That countering stigma among young people in higher education and vocational training is also critical to encouraging students enrolled in university and TAFE to seek help early for mental health issues.

→ RECOMMENDATION 4.2:

That the Victorian Government increase mental health literacy training for young people in schools through programs such as *Live4Life* to enhance their awareness and up-take of supports available, and to reduce the stigma associated with mental health issues.

40 Submission 33, Associate Professor Jennifer Martin—School of Global, Urban and Social Studies, RMIT University, pp.2-3.

41 Venville, A. & Street, A. (2012) *Unfinished business: student perspectives on disclosure of mental illness and success in VET*. Adelaide, National Centre for Vocational Education Research, pp.7-8.

42 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, pp.64-65.

43 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.64.

4.3.3 Student screening

The Committee observed that improvement is needed in the screening of students for mental health issues. As can be seen from Table 4.2, after information collected on entry into primary school, no screening takes place until students reach year 10. Some information about levels of morale and distress among students enrolled in years 5–12 is gathered each year through the *Victorian attitudes to school survey* (see Box 4.2). However, the Committee found that this survey only captures information about student wellbeing at an aggregate cohort level. It does not enable schools to identify emerging mental health issues within individual students. The Committee considered that this represents a significant gap.

Table 4.2: Screening of students for mental health issues

Initiative	Target group	Key features
Screening as part of the Victorian Child and Adolescent Monitoring System	<ul style="list-style-type: none"> Primary school students 	<ul style="list-style-type: none"> Mental health data collected by teachers in the first year of primary school
School Entrant Health Questionnaire	<ul style="list-style-type: none"> Primary school students 	<ul style="list-style-type: none"> Completed by parents on point of entry to school Data collected provides a flag for follow-up issues.⁴⁴
Student Mapping Tool to develop Managed Individual Pathways	<ul style="list-style-type: none"> High school students attending year 10 	<ul style="list-style-type: none"> Online tool used by teachers and principals Screens for risk factors associated with student disengagement and early leaving Tracks and evaluates interventions made to support students at risk of disengagement.⁴⁵

Source: Compiled by Family and Community Development Committee.

The Committee identified that more can be done to develop better tools to identify students at risk mental illness and those at risk of disengaging from school. The BSL, for example, suggested that ensuring the continuing assessment of students as they progress through school would provide the basis of ‘responsible support, including specialist health and welfare services, as well as alternative flexible learning.’⁴⁶

Better student screening was acknowledged as an area for further development by the Department of Education and Early Childhood Development (DEECD). Ms Kris Arcaro, Director, Student Wellbeing and Engagement Division, School Education Group, DEECD, informed the Committee that DEECD has commissioned work to research the range of assessment tools that could be used in educational settings to monitor students’ health and wellbeing needs.⁴⁷

⁴⁴ *Transcript of evidence 29*, Department of Education and Early Childhood Development, p.2.

⁴⁵ *Response to questions on notice*, Department of Education and Early Childhood Development, 13 June 2012, p.7.

⁴⁶ *Transcript of evidence 14*, Brotherhood of St Laurence, 28 February 2012, p.4.

⁴⁷ *Transcript of evidence 29*, Department of Education and Early Childhood Development, p.7.

4.3.4 Mental health literacy training for educational staff

Inquiry participants told the Committee that training teachers and other educational staff in identifying and responding to students with mental health problems is vital to supporting those students to remain engaged in education. For example, Mission Australia commented that:

There is a need to ensure education providers and services are appropriately equipped to [support students with mental illness]. This includes increasing their mental health literacy but also ensuring they have the appropriate information they require to seek and engage additional support to help the young people they are working with.⁴⁸

The Committee is aware that DEECD has been working over the past year to increase understanding and awareness of mental health issues among teachers and other educational staff. Ms Arcaro told the Committee that a professional learning program is currently in development that will target teachers in government and non-government schools. This program will aim to build ‘a common understanding of the issues around mental health and strategies and how you identify young people very early.’⁴⁹

The Committee understands that on-line curriculum modules will be made available to all Victorian education workforces, including staff within the Catholic and Independent sectors, from Term 4, 2012.⁵⁰ These modules will be provided in a flexible and self-paced format that allows participants to select the most appropriate modules for their education setting.

The Committee also considered that there could be significant benefit in teachers obtaining a Mental Health First Aid certificate, described in Box 4.5. Professor Killackey for example, suggested that including this as a requirement in teacher professional training would help to develop the capacity of educators to be aware of and respond to the signs of emerging mental illness.⁵¹

⁴⁸ *Submission 29*, Mission Australia, p.19.

⁴⁹ *Transcript of evidence 29*, Department of Education and Early Childhood Development, p.5.

⁵⁰ *Response to questions on notice*, Department of Education and Early Childhood Development, p.2.

⁵¹ *Transcript of evidence 13*, Orygen Youth Health, p.7. See also *Transcript of evidence 28*, Centre for Youth Mental Health, p.5.

Box 4.5 Mental Health First Aid

Mental Health First Aid is 12-hour training program that was developed a little over 10 years ago by Professor Anthony Jorm and his wife, Ms Betty Kitchener. The program teaches members of the public about how to help a person who is either developing a mental health problem or in a mental health crisis until appropriate professional help is available. Tailored programs have also been developed for professionals within specific work roles where the likelihood of coming into contact with someone experiencing a mental health problem is higher.

Variants of Mental Health First Aid have been developed to teach people about how to respond to the particular needs of young people or indigenous Australians with emerging mental health problems. For example, a Youth Mental Health First Aid program has previously been delivered to high school teachers in South Australia.

An evaluation of this training found that the training increased teachers' knowledge about mental illness and treatment interventions as well as their confidence in providing help to students and colleagues. The training also appeared to have an indirect effect on students, who reported receiving more information about mental illness from school staff.⁵²

The motivation for developing Mental Health First Aid was the high prevalence of mental illness in the community and the likelihood of people encountering a person with a developing mental health problem. It was also recognised that many people with mental health problems do not get professional help but that 'people are more likely to get help when someone else suggests it and when people around them are supportive of them getting help.'⁵³

The Committee heard that one per cent of the adult population of Australia (170,000 people) has now been trained in Mental Health First Aid and the program has also been brought to 16 other countries.⁵⁴

Source: Compiled by Family and Community Development Committee.

FINDING 5

That staff within schools require assistance such as training in Mental Health First Aid to identify students at risk of disengaging from education because of mental illness.

→ RECOMMENDATION 4.3:

That the Victorian Government develops a strategy to support the education sector to identify the risk factors for mental illness, including:

- Enhancing skills of teachers, guidance counsellors and other education professionals to recognise and respond to the symptoms of mental illness.
- Incorporating Mental Health First Aid as part of teacher training.
- Identifying, raising awareness and increasing relevant service support.

52 Jorm, A., F. & al., E. (2010) 'Mental health first aid training for high school teachers: A cluster randomised trial'. *BMC Psychiatry*, Vol. 10.

53 *Transcript of evidence 28*, Centre for Youth Mental Health, p.5.

54 *Transcript of evidence 28*, Centre for Youth Mental Health, p.5.

4.4 Support services for students with mental illness

Inquiry participants told the Committee that timely and individualised support is critical in preventing students with mental illness disengaging from education. Mission Australia, for example, identified that such support is critical to enhancing students' social inclusion and subsequent workforce participation.⁵⁵

The Committee heard about a range of supports available in schools for students with mental illness (see Table 4.3). In addition, the Committee recognises that student engagement in general is an important element of DEECD education policies and frameworks.⁵⁶

In contrast, the Committee identified that there is limited support available in higher education settings for people experiencing mental illness (discussed in Section 4.4.2).

4.4.1 Support services in schools

The Committee is aware that a range of support services and re-engagement programs are available to assist young people experiencing mental health issues to stay engaged in education.⁵⁷ These are outlined in Table 4.3.

⁵⁵ *Submission 29*, Mission Australia, pp.8-9.

⁵⁶ *Transcript of evidence 29*, Department of Education and Early Childhood Development, p.5. For example, see Department of Education and Early Childhood Development (2010) *Pathways to re-engagement through flexible learning options: A policy direction for consultation*. Melbourne, Student Wellbeing Division, Department of Education and Early Childhood Development, State of Victoria, p.6. Department of Education and Early Childhood Development (2009) *Blueprint for education and early childhood development*. Melbourne, Student Wellbeing and Support Division Office of Government School Education, Department of Education and Early Childhood Development, State of Victoria, p.11. Department of Education and Early Childhood Development (2009) *Effective schools are engaging schools: student engagement policy guidelines*. Melbourne, Student Wellbeing and Support Division Office of Government School Education, Department of Education and Early Childhood Development, State of Victoria, p.8.

⁵⁷ *Transcript of evidence 29*, Department of Education and Early Childhood Development, pp.7-8.

Table 4.3: Support services and programs for students with mental health issues

Lead Government	Program	Target group	Overview
Commonwealth Government	Youth Connections	Secondary school students aged 13 to 19 who are disengaged/ at risk of disengaging from school.	<ul style="list-style-type: none"> National program provided through community sector organisations. Individualised case management support to reconnect/maintain young people's engagement in school, including outreach services.⁵⁸
Victorian Government	Student Support Services	Secondary school students who face barriers to learning.	<ul style="list-style-type: none"> Provided across all Victorian schools. Includes psychologists, guidance officers, speech pathologists, social workers, visiting teachers and other professionals. Currently being reformed to increase the focus on identifying and responding to child and adolescent mental health issues.⁵⁹
Victorian Government	Student Welfare Coordinators	Government secondary school students.	<ul style="list-style-type: none"> Responsible for helping students address issues such as truancy, bullying, drug use and depression.
Victorian Government	Primary Welfare Officer Initiative	Primary school students.	<ul style="list-style-type: none"> Promotes a whole school approach to health and wellbeing. Key focus on tackling bullying and supporting students with behavioural, mental health and welfare issues.
Victorian Government	Child and Adolescent Mental Health Services School Early Action Program	Primary school students.	<ul style="list-style-type: none"> Delivers evidence-based interventions in school settings by child and adolescent mental health services.⁶⁰
Victorian Government	Managed Individual Pathways	Government secondary school students aged 15 years and over.	<ul style="list-style-type: none"> Provides students with individual career action plans to aid successful transition to further education and employment. Additional support available for students at risk of disengaging or having difficulty transitioning to further education, training or employment.

58 Submission 29, Mission Australia, p.8.

59 Department of Human Services (2009) *Because mental health matters: Victorian mental health reform strategy 2009-2019*, p.78. Department of Education and Early Childhood Development (2009) *Strengthening student support services directions paper: The way forward*. Melbourne, Student Wellbeing and Support Division Office of Government School Education, Department of Education and Early Childhood Development, State of Victoria, p.12.

60 *Transcript of evidence 29*, Department of Education and Early Childhood Development, pp.4-5.

Lead Government	Program	Target group	Overview
Victorian Government	School Focused Youth Service	Vulnerable primary and secondary school students aged between 10 and 18 years.	<ul style="list-style-type: none"> Joint initiative between the Department of Education and Early Childhood Development (DEECD) and the Department of Human Services (DHS). Facilitates linkages and coordination of services between schools and community service organisations at a local level.
Victorian Government	Youth Partnerships	Vulnerable primary and secondary school students aged between 10 and 18 years.	<ul style="list-style-type: none"> Demonstration projects being established to design and trial holistic approaches to improve engagement in education and training.⁶¹

Source: Compiled by Family and Community Development Committee.

The Committee identified that, while there are a range of supports in place, careful monitoring and evaluation is needed to ensure these programs are effective in supporting young people with a mental illness to complete secondary schooling.

4.4.2 Support services within university and TAFE

The Committee found that there are limited post-secondary supports for young people with mental illness. For example, Mr Terry Laidler, Chair of the former Victorian Mental Health Reform Council (VMHRC), commented that services in university and TAFE settings are not equipped to identify mental health problems experienced by students:

Short of giving kids special consideration, I don't think [universities and TAFEs] are well geared up to identify the problem and then work with their student who has had that problem to make sure they are not lost to the education system.⁶²

The gap in support services in post-secondary education was also recognised in the Federal Inquiry. The Federal Inquiry report quoted Mr Brian Graetz from *beyondblue*, who explained that TAFEs and universities are lagging behind schools in the support provided for young people with mental illness. Mr Graetz commented that TAFEs and universities:

Are probably where secondary schools were 10 years ago ... They are very much in the early days [of dealing with mental health issues among students] ... In Australia the primary school sector and the secondary school sector has gone much further around this.⁶³

The Committee identified the following concerns with support services at universities and TAFEs:

- Supports generally rely on self-identification, which can be hampered by the stigma associated with mental health problems (as discussed in Section 4.3.2)

61 *Response to questions on notice*, Department of Education and Early Childhood Development, 13 June 2012, p.7.

62 *Transcript of evidence 4*, Victorian Mental Health Reform Council, 7 November 2011, pp.9-10.

63 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.45.

- Supports are generally limited to counselling provided by student support services and learning support provided by DLOs. This gives rise to a number of problems:
 - Many DLOs come from a physical disability background and may not be skilled in providing support to students with mental illness.⁶⁴
 - Not all DLOs consider support of students with mental illness to be part of their role.⁶⁵
 - Students can be reluctant to access services because they ‘may not necessarily view their mental health related-difficulties as fitting within notions of disability’⁶⁶—for example, DEECD advised the Committee that ‘the general model in TAFE institutes for supporting the students [with mental illness], particularly those who self-identify, is that if they self-identify on enrolment that they have a disability then they come to the attention of the learning support services ...’⁶⁷

The Federal Inquiry recognised that mental health promotion and support for people with mental illness should extend beyond DLOs and student support services. It noted that:

Assisting students with mental illness and promoting the mental health of all students on campus is a responsibility that extends beyond disability liaison officers and the broader student services.

University and TAFE administrators, teaching staff and the wider education community all have an important role to play in this regard, from setting the direction from the top and encouraging inclusivity to noticing early warning signs and encouraging students to seek help from professionals.⁶⁸

The Committee heard that the Victorian Government is currently implementing changes to supports for students with mental illness in universities and TAFEs. Mr Andrew Abbot from DEECD told the Committee that the Department is currently promoting guidelines to facilitate improved education outcomes for students with mental illness. He also indicated that a Mental Health First Aid training kit has been rolled out to all TAFE institutions.⁶⁹

The Committee also supports recommendations made by the Federal Inquiry to develop a national approach to educate teaching and general staff to provide support to students with mental illness.⁷⁰

FINDING 6

That Disability Liaison Officers (DLOs) may not provide adequate support for people with mental illness due to a focus on physical disability.

64 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, pp.62-3, 70.

65 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.69.

66 *Submission 37*, Psychosocial Research Centre, p.2.

67 *Transcript of evidence 29*, Department of Education and Early Childhood Development, p.10.

68 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.71.

69 *Transcript of evidence 29*, Department of Education and Early Childhood Development, p.10.

70 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.72.

4.5 Returning to education and training

The Committee heard that it is important to provide pathways back into education and training for people with mental illness who have already ‘fallen through the gaps and are now disengaged from education, training, and employment.’⁷¹ Strategies to re-engage people in these circumstances include specialised support and intervention and approaches that build self-esteem and confidence.

Inquiry participants emphasised that people with mental illness who have become disengaged from learning pathways ‘require additional support to assist them to re-engage with education, training and employment.’⁷² Ms Collister from the MI Fellowship, for example, expressed the view that without specialised approaches to education, people with mental illness ‘will not achieve workplace participation.’⁷³

Jesuit Social Services (JSS) highlighted several factors that can make re-engagement in education and training difficult for people with mental illness, including low self-esteem and reduced self-confidence based on previous poor educational experiences. JSS also identified that people with mental illness may also be ‘intimidated or deterred by traditional education approaches and settings.’⁷⁴ In addition, the Committee heard that not all health professionals are supportive of people with mental illness re-engaging with education.

Dr Geoff Waghorn from the Queensland Centre for Mental Health Research explained that there can be a culture of low expectations among health practitioners. He commented that this ‘causes health professionals not to think of mainstream education or employment as part of an individual’s recovery plan.’⁷⁵ Similarly, the Psychosocial Research Centre noted that ‘lack of knowledge, encouragement or support from mental health workers’ can be a barrier to re-engagement in education.⁷⁶ This issue is discussed further in Chapter 8.

FINDING 7

That people with mental illness who are disengaged from education can have complex needs and may require tailored support to assist them to return to education and training.

4.6 Re-engagement pathways

The Committee received extensive evidence on the importance of supporting people with mental illness to re-engage in education and training in fostering workforce participation. However, it received little detailed evidence as to how this could most effectively be achieved.

The Committee identified some innovative approaches within the Community Victorian Certificate of Applied Learning (VCAL) and the State’s VET system to

⁷¹ *Submission 29*, Mission Australia, p.4. See also *Transcript of evidence 25*, Mental Illness Fellowship of Victoria, p.4.

⁷² *Submission 29*, Mission Australia, p.6.

⁷³ *Transcript of evidence 25*, Mental Illness Fellowship of Victoria, p.5.

⁷⁴ *Submission 39*, Jesuit Social Services, p.9.

⁷⁵ *Submission 42*, Dr Geoff Waghorn—Queensland Centre for Mental Health Research, p.12.

⁷⁶ *Submission 37*, Psychosocial Research Centre, p.1.

support people with mental illness in returning to learning at senior-secondary and post-secondary level. Box 4.6 outlines Community VCAL and VET in more detail.

Box 4.6 Re-engagement pathways

Community Victorian Certificate of Applied Learning (VCAL)—VCAL is a state-wide years 11 to 12 flexible study program run in parallel to the Victorian Certificate of Education (VCE).⁷⁷ VCAL students undertake units in literacy and numeracy, personal development, work-related and industry skills.⁷⁸

Community VCAL programs are VCAL programs delivered in alternative, supportive, learning environments to enable students disengaged from mainstream schools ‘to complete year 12 or equivalent ... and to make a successful transition ... to further education, training or employment.’

Programs are funded through the Department of Education and Early Childhood Development (DEECD) under Student Resource Package (SRP) funding. Under this model, Community VCAL students are enrolled as students in Victorian Government schools. These schools receive SRP funding for these students, which they then pass on to the external Community VCAL providers.⁸⁰

Vocational Education and Training (VET)—post-secondary pathways back into education and training are mainly provided through the State’s VET system, which includes courses offered by Technical and Further Education (TAFE) institutes. VET providers deliver training across a range of courses and qualifications, including:

- entry level training such as apprenticeships, traineeships, basic literacy numeracy, return-to-learning programs, and work skills
- advanced vocational training including training for paraprofessionals
- diploma and advanced diploma courses.⁸¹

TAFEs are the largest providers of VET. For example, in 2010, approximately 69 per cent of VET students undertaking government subsidised training were enrolled in TAFE institutes.⁸² However, VET is also delivered by private registered training organisations (RTOs) and adult and community education (ACE) providers.⁸³

Importantly, catering for higher-needs learners and those with poor prior records of educational achievement are core objectives of VET in Victoria.⁸⁴ Several VET providers, including TAFEs and community sector RTOs, offer tailored return-to-learning programs designed to support students with severe mental illness to re-engage in education and training.

Source: Compiled by Family and Community Development Committee.

77 Myconos, G. (2011) *A path to re-engagement: Evaluating the first year of a Community VCAL education program for young people*. Melbourne, Brotherhood of St Laurence, pp.1-2.

78 Department of Education and Early Childhood Development (2012) *Re-engagement programs: A starter kit*. Accessed on 11 September 2012 from <http://www.eduweb.vic.gov.au/edulibrary/public/postcomp/Re-engageStarterKit.pdf>.

79 Department of Education and Early Childhood Development (2009) *Future directions for Community VCAL programs*. Melbourne, Youth Transitions Division, Department of Education and Early Childhood Development, State of Victoria, p.4.

80 Department of Education and Early Childhood Development (2009) *Future directions for Community VCAL programs*, p.9.

81 Essential Services Commission (2011) *VET fee and funding review—Volume II: Technical analysis*. Melbourne, Essential Services Commission, p.5.

82 Essential Services Commission (2011) *VET fee and funding review—Volume II: Technical analysis*, p.9.

83 Essential Services Commission (2011) *VET fee and funding review—Volume II: Technical analysis*, p.9.

84 Essential Services Commission (2011) *VET fee and funding review—Volume II: Technical analysis*, pp.27-28.

FINDING 8

That participants identified programs such as Victorian Certificate of Applied Learning and training courses offered by TAFEs as good concrete examples of providing alternative and flexible education and training pathways, with many success stories.

4.6.1 Community VCAL

Community VCAL is a form of VCAL specifically tailored to the needs of students who have become disengaged from mainstream schooling.⁸⁵ It is targeted at students affected by factors such as homelessness, family trauma, poverty, mental health problems, and behaviour issues.⁸⁶ The Committee received evidence regarding the important role of Community VCAL in supporting re-engagement in senior secondary education by students with mental illness.

Since 2009, BSL has delivered a Community VCAL program to around 50 young people aged between 15 and 19 years of age at its Frankston High Street Centre. Mr Michael Horn, Senior Manager of Research and Policy at BSL, advised the Committee that young people with mental health or related issues make up about a third of the students.⁸⁷ He added that:

Two of last year's cohort attempted suicide, so they are a significant group of people that we are trying to engage in meaningful learning to get them back online. It is a difficult group. Generally they have a history of being managed out of the mainstream education system or have become so-called 'refusers'.⁸⁸

Mr Horn explained that key components of BSL's Community VCAL program include small class sizes (approximately 25 students per class) and the provision of integrated welfare and educational support:

The model that we have developed has a higher student-to-staff teaching ratio, but we also felt the imperative to have a welfare role that provides non-educational support to keep those kids engaged and get them into the school and also help them, because they are doing community VCAL, achieve their [work experience] placements outside of the Brotherhood setting.⁸⁹

Notably, an evaluation of the first year of BSL's Community VCAL program found that attendance was high, at 79 per cent, while academic and vocational outcomes were also encouraging:

- 10 out of 11 year 12 students graduated and 12 out of 14 year 11 students progressed to year 12.
- All students were also enrolled in at least one VET course, with one gaining an apprenticeship and five gaining traineeships.⁹⁰

BSL expressed the view that the flexible learning options and intensive support provided through Community VCAL are an effective approach to re-engaging

85 Department of Education and Early Childhood Development (2010) *Pathways to re-engagement through flexible learning options: A policy direction for consultation*, p.27.

86 Department of Education and Early Childhood Development (2009) *Future directions for Community VCAL programs*, p.3.

87 *Transcript of evidence 14*, Brotherhood of St Laurence, p.6.

88 *Transcript of evidence 14*, Brotherhood of St Laurence, p.6.

89 *Transcript of evidence 14*, Brotherhood of St Laurence, p.6.

90 Myconos (2011) *A path to re-engagement: Evaluating the first year of a Community VCAL education program for young people*, p.vi.

students with mental illness. Dr Dina Bowman, Principal Researcher at the BSL's Research and Policy Centre, explained that:

[Mainstream] education and training providers have limited flexibility in terms of pedagogy and curriculum, and our experience would suggest that there is insufficient welfare support and access to specialist help to ensure effective participation of students with mental health barriers to learning.⁹¹

However, the Committee heard that one of the challenges faced by Community VCAL providers such as BSL is the cost of providing integrated and holistic support.

Mr Horn explained that BSL relies on 'very generous funding from a philanthropic trust' to employ the additional teaching and welfare support staff required to support the learning needs of its student cohort.⁹² BSL advised the Committee that the Victorian Government's decision to reduce its funding of VCAL coordination support in October 2011 made it difficult for providers to deliver integrated wellbeing and educational support. BSL called for the Victorian Government to reinstate its funding for coordinator support, which Mr Horn identified as critical to the effectiveness of integrated models.⁹³

FINDING 9

That flexible learning options and intensive support provided through Community VCAL programs may enable people with mental illness to re-engage in senior secondary education.

4.6.2 VET pathways

Inquiry participants told the Committee that supporting people with mental illness to undertake VET is a key pathway to fostering workforce participation by people with mental illness. For example, in its submission, VEOHRC stated that:

Adequate vocational education and training assistance plays a critical role in assisting transition to work. Sixty three per cent of people with mental health conditions are reported to have no post school qualifications and have a greater drop-out rate and poorer labour market outcomes than other Vocational Education and Training (VET) participants.⁹⁴

Research also supports the value of VET qualifications in advancing workforce participation. For example, NCVER has found that 'completing a VET qualification significantly increases the employment probability of all labour market participants.'⁹⁵ This is especially true of people with disability or mental illness who are out of work at the time of enrolment.⁹⁶

Responsibility for funding VET is shared between the Victorian and Commonwealth governments, although the Victorian Government retains primary responsibility

91 *Transcript of evidence 14*, Brotherhood of St Laurence, p.4.

92 *Transcript of evidence 14*, Brotherhood of St Laurence, pp.6-7.

93 *Transcript of evidence 14*, Brotherhood of St Laurence, p.4, p.7.

94 *Submission 41*, Victorian Equal Opportunity and Human Rights Commission, p.5.

95 Mavromaras, K. & Polidano, C. (2010) *The role of vocational education and training in the labour market outcomes of people with disabilities*. Adelaide, National Centre for Vocational Education Research, p.8.

96 Mavromaras & Polidano (2010) *The role of vocational education and training in the labour market outcomes of people with disabilities*, p.8.

for administering VET, allocating funding, registering training organisations and accrediting courses.⁹⁷ In particular, the Victorian Government directly subsidises more than 200,000 VET enrolments each year through the Victorian Training Guarantee (VTG) and related fees concessions.⁹⁸ These are outlined in Box 4.7 below. Since the Committee collected evidence, there have been significant policy developments at both Commonwealth and Victorian Government levels which have not been considered by the Committee. The Committee has concerns about the unintended consequences for people with mental illness.

Box 4.7 Subsidies for Vocational Education and Training (VET) students funded by the Victorian Government.

Victorian Training Guarantee (VTG)—entitles Victorian students who meet certain eligibility criteria to a subsidised training place in an accredited VET course. Eligibility criteria are based on students' citizenship, age, nature of the course being undertaken and whether the student is an apprentice.⁹⁹

Fees concessions—VET courses funded under the VTG operate under a co-contribution model. This means that students enrolled in government-subsidised training must cover a portion of their tuition fees. However, people with mental illness may be eligible for concessions on their tuition fees if they hold, or are a dependent of someone who holds, a Commonwealth Health Care Card, Pensioner Concession Card, or Veterans Gold Card.¹⁰⁰

Source: Compiled by Family and Community Development Committee.

4.6.3 Providing flexible learning options within VET

Inquiry participants told the Committee that it is critical to incorporate flexibility within VET programs to facilitate the effective re-engagement of people with mental illness. Notably, 2010 data reported by NCVER in its submission shows that more than 21 per cent of VET students with disclosed mental illness withdraw before completing units of study. This compares with withdrawal rates of around nine per cent among VET students with no disability or mental illness.¹⁰¹

The Committee heard that people with mental illness undertaking VET can have low self-confidence due to previous poor educational experiences. Lantern suggested that they may find the TAFE environment 'overwhelming; very busy, crowded confusing and intimidating.'¹⁰² Other Inquiry participants highlighted the importance of the flexible scheduling of class times. For example, Ms Collister from MI Fellowship explained that:

It is really important that classes start late. Because people take medication, that means they cannot attend class early in the morning.¹⁰³

97 Productivity Commission (2011) *Vocational education and training workforce: Productivity Commission research report*. Canberra, Commonwealth of Australia, p.421.

98 Essential Services Commission (2011) *VET fee and funding review—Volume II: Technical analysis*, p.5.

99 Essential Services Commission (2011) *VET fee and funding review—Volume II: Technical analysis*, p.40.

100 Essential Services Commission (2011) *VET fee and funding review—Volume II: Technical analysis*, p.73.

101 *Submission 31*, National Centre for Vocational Education Research (NCVER), p.2.

102 *Submission 36*, Lantern, p.2.

103 *Transcript of evidence 25*, Mental Illness Fellowship of Victoria, p.4.

The Committee considered that TAFEs and other mainstream VET settings could address the specific needs of people with mental illness through a number of flexible initiatives. For example, Associate Professor Martin from RMIT identified the following approaches from her research:

- online access to course materials
- flexible assessment tasks and timelines
- structured classes that do not require full attendance and participation
- maintaining contact with teaching staff during periods of ill health
- using information technology to facilitate partnerships between educators and students to assist students to remain engaged with their studies during periods of mental illness.¹⁰⁴

FINDING 10

That greater flexibility within VET courses including use of information technology and tailored timetabling can assist students with mental illness to remain engaged in training and education.

4.6.4 Supported return-to-learning programs

Some Inquiry participants were of the view that effective re-engagement of people with mental illness in VET requires tailored programs that provide holistic approaches to support that address health and wellbeing in addition to educational needs.¹⁰⁵

The Committee heard evidence about the benefits of VET programs that provide intensive individualised support in assisting people with mental illness to return to learning and to gain confidence and hope. These supported return-to-learning VET programs are delivered in separate classroom environments specifically designed to support the learning needs of people with severe mental illness (usually psychosis). As Ms Collister from the MI Fellowship explained to the Committee:

If you can imagine that half the work that happens in that classroom is work that is about how you manage doing some work and also hearing voices at the same time. How do you manage when your anxiety is so high that you cannot focus on your work? How do you manage being really restless or alternatively really sedated in a classroom setting?¹⁰⁶

Supported return-to-learning programs facilitate the re-engagement of people with mental illness through:

- delivering education and training in tailored learning environments different to environments in which participants may have previously had poor learning experiences¹⁰⁷

104 *Submission 33*, Associate Professor Jennifer Martin—School of Global, Urban and Social Studies, RMIT University, p.4.

105 See, for example, *Submission 39*, Jesuit Social Services, pp.4-5.

106 *Transcript of evidence 25*, Mental Illness Fellowship of Victoria, p.4.

107 Ennals, P., Cartwright, E., & Rinuado, B. (2010) 'Supported education: One pathway to social inclusion for people with interrupted educational trajectories'. *newparadigm: The Australian Journal on Psychosocial Rehabilitation*, Vol. Winter, pp.12-16, p.15.

- including holistic approaches to welfare and counselling support alongside teaching support
- assertive follow up of absenteeism and close coordination between program staff and participants' clinical care team
- teaching through a highly flexible curriculum that allows for part-time attendance and interruptions to study due to relapses in symptoms.

Table 4.4 outlines supported return-to-learning VET programs offered by MI Fellowship and Wodonga TAFE.

Table 4.4: Tailored return-to-learning programs for students with mental illness

Program	Overview
Mental Illness Fellowship of Victoria's return-to-learning program	<ul style="list-style-type: none"> • Delivered to between 15 and 20 students each year.¹⁰⁸ • Aims to help people with mental illness gain Certificate level qualifications and provides pathways to work or further vocational training. • Delivered in a tailored learning environment catering to people with mental illness.¹⁰⁹ • Course offerings include a Certificate II/III level, General Education for Adults as well as certificates in Community Services, Hospitality and Business.
Wodonga TAFE's Return to Education and Learning (REAL) Options program	<ul style="list-style-type: none"> • Aims to assist students to have 'a real TAFE experience' and attain the qualifications and confidence to pursue further education or vocational pathways. • Potential students are referred to the program by case managers in local area mental health services and PDRSS. • Course structure is tailored each year to the needs of participants. • Teaching occurs in a small, supportive classroom environment on campus.¹¹⁰

Source: Compiled by Family and Community Development Committee.

The Committee considered that supported return-to-learning programs are encouraging approaches to re-engaging people with mental illness in education and training. However, the Committee was of the view that these supported pathways must co-exist with appropriately tailored mainstream pathways. For example, Dr Waghorn expressed concern about delivering education and training in separate classroom environments on the grounds 'that some people would consider supported pathways 'stigmatising through association.'¹¹¹

The Committee also determined that programs need to be carefully evaluated to determine their effectiveness and whether they can be scaled up to support larger

108 Ennals, Cartwright, & Rinuado (2010) 'Supported education: One pathway to social inclusion for people with interrupted educational trajectories', p.13.

109 *Transcript of evidence* 25, Mental Illness Fellowship of Victoria, p.4.

110 The National VET Equity Advisory Council (2012) *Wodonga TAFE: Return to Education and Learning (REAL) options for students with mental health issues*. Accessed on 11 September 2012 from http://www.nveac.natese.gov.au/___data/assets/pdf_file/0003/54345/VIC_Wodonga_TAFE_REAL_Options.pdf.

111 *Submission* 42, Dr Geoff Waghorn—Queensland Centre for Mental Health Research, p.11.

numbers of people with mental illness to return to learning. In particular, it identified that the cost-effectiveness of supported VET pathways needs to be more closely examined. This includes determining whether VET programs involving intensive support for small numbers of students are financially viable approaches.

FINDING 11

That diverse approaches are needed to assist people with mental illness to return to education and training. Supported return-to-learning pathways must co-exist with appropriately tailored mainstream pathways.

4.6.5 Individualised support for students within mainstream settings

Rather than delivering supported education in separate classroom environments, Dr Waghorn told the Committee that ‘there is a growing evidence-base that individual support for mainstream education and vocational training can be very effective.’¹¹²

Under this approach, vocational specialists located within mental health services assist people with mental illness to enrol in educational and training programs as part of their recovery. Following enrolment, vocational specialists provide support to students to assist them in managing anxiety and disclosure of mental illness when returning to study. They also liaise with DLOs and other student support services to assist in identifying educational support needs. Table 4.5 outlines the results of trials of this type of approach in Australia.

112 *Submission 42*, Dr Geoff Waghorn—Queensland Centre for Mental Health Research, p.11.

Table 4.5: Individual placement and support for people with mental illness returning to education

Type of Program	Program	Target group	Overview
Individual Placement and Support (IPS)	Orygen Youth Health Early Psychosis Prevention and Intervention Centre trial (Victoria)	People aged between 15 and 25 in the North Western regions of Melbourne	<ul style="list-style-type: none"> • First IPS trial conducted in 2005 and 2006.¹¹³ • Education consultant works alongside clinical mental health team to assist clients to re-engage in education. • By the end of the trial, 18 of the 19 participants had successfully completed their year of education.¹¹⁴
IPS and peer support	Hunter New England Mental Health Service Trial (New South Wales)	People aged 16–30 years who had been diagnosed with psychotic or related illness in the previous five years.	<ul style="list-style-type: none"> • Operated between 2007 and 2008. • Occupational therapists located within an early psychosis rehabilitation team provided support to clients to access courses at TAFE, university and private VET providers. • On-site student support services liaised with campus disability support services to assess educational support needs, assist with enrolment and career planning, disclosure counselling, anxiety management, time management, and study skills. • Ongoing peer support group established to address concerns and assist with the challenges of studying. • Evaluation showed that 14 of the 20 participants had either completed or were continuing with their courses.¹¹⁵

Source: Compiled by Family and Community Development Committee.

The Committee considered the results of these trials promising. However, it identified that significant work is needed to assess the effectiveness of these emerging approaches. For example, OYH advised the Committee that there is very little research in relation to effective interventions to support people with mental illness to re-engage in education.¹¹⁶ The Committee determined that the Victorian Government should undertake a strategic review of approaches to supporting people with mental illness in returning to education to identify best-practice principles.

FINDING 12

That there needs to be improved understanding of how tailored education programs can assist people with mental illness to effectively re-engage in education and training.

113 Killackey, E., Jackson, H.J., & McGorry, P.D. (2008) 'Vocational intervention in first-episode psychosis: Individual placement and support v. treatment as usual'. *The British Journal of Psychiatry*, Vol. 193, pp.114-20.

114 *Transcript of evidence 13*, Orygen Youth Health, p.5.

115 Robson, E., Waghorn, G., Sherring, J. et al. (2010) 'Preliminary outcomes from an individualised supported education program delivered by a community mental health service'. *British Journal of Occupational Therapy*, Vol. 73, No. 10, pp.481-86.

116 *Submission 18*, Orygen Youth Health, p.8.

→ RECOMMENDATION 4.4:

That the Victorian Government develops a strategy to increase understanding of effective programs that support people with mental illness in returning to education and training, including:

- Developing and trialling models of flexible course delivery for VET students with mental illness.
- Assessing the potential for Individual Placement and Support (IPS)-style interventions to support people with mental illness returning to education.
- Comparing the cost-effectiveness of different programs and interventions.

Chapter Five: Changing perceptions

Findings

1. That despite improvement in public awareness and understanding of depression, negative perceptions and stereotypes of people with severe mental illness such as psychosis are widespread.
2. That perceptions and attitudes toward people with mental illness in the workforce have not improved to the same extent achieved in the broader community.
3. That disclosure can be important in the successful employment of people with mental illness.
4. That fear of stigma can lead people to keep their mental illness hidden within the workplace.
5. That disclosure of mental illness by employees can contribute to improved perceptions of people with mental illness in the workplace.
6. That a targeted awareness-raising campaign used in conjunction with other strategies can be effective in promoting positive perceptions of the employment of people with mental illness.
7. That community education programs that individually target managers, supervisors, human resources staff, and general staff can contribute to changing perceptions of people with mental illness in employment.
8. That practical support and information for employers in managing employees with mental illness is an essential part of any campaign to improve responses to people with mental illness in employment.
9. That local government and industry associations have a key role in showcasing the positive experiences of major and local employers in recruiting and retaining workers with mental illness.
10. That the Victorian and local governments can play a leadership role in improving workplace responses to people with mental illness through championing the public sector employment of people with mental illness.

The Committee found that public awareness of mental illness has increased over the past decade. However, many people with mental illness continue to face stigma and discrimination in the workplace.

Inquiry participants told the Committee that people with mental illness face increased risk of being ruled out of recruitment and promotion processes because of misconceptions about the ability of people with mental illness to cope with the demands of work. People can also experience harassment and discrimination because of stigma associated with mental illness.

The Committee also heard that a fear of being stereotyped and discriminated against can lead many people to keep their mental illness hidden within the workplace. This can prevent people from getting the help they need to maintain their employment during times when they are unwell.

The Committee identified that a targeted strategy is needed to change perceptions and behaviours towards people with mental illness in the workplace and to promote the business and community benefits of recruiting and retaining workers with mental illness. It also determined that the Victorian and local governments can contribute to cultural change in this area through championing the employment of people with mental illness in public sector recruitment.

5.1 Stigma and participation in employment

The Committee heard that negative perceptions and attitudes towards people with mental illness are widespread in the workforce. These attitudes and perceptions frequently manifest in negative actions towards people with mental illness such as social exclusion and discrimination. These negative attitudes and behaviours can be labelled stigma.

5.1.1 Defining stigma

Stigma in relation to mental illness refers to the negative attitudes and perceptions that people can hold in relation to mental illness. It leads to judgements about people with mental illness without a full understanding of the experience of mental illness.

Stigma can be obvious and direct, such as negative and derogatory remarks. Or it can be subtle, such as assuming that work is too stressful for people with mental illness or assuming that a person is unstable, violent or dangerous because of their mental illness. Stigma can also affect how people with mental illness judge themselves.

Stigma often involves the use of negative labels to identify a person living with mental illness. It leads to disrespect for people with mental illness. This can include lack of understanding (for example, by family, friends or others) and experiences of bullying, harassment and discrimination. It can also result in discrimination against people with mental illness in a range of areas, including employment. For example, the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) highlighted that:

If people disclose their mental illness on a job application, often they are not interviewed—that is what they tell us—or if they are interviewed, they do not get the job or there are questions raised about some of these stereotypes around: ‘Will you be safe?’, ‘What is your criminal record history?’ and things like that.¹

¹ *Transcript of evidence 10*, Victorian Equal Opportunity and Human Rights Commission, 21 November 2011, p.5.

Stigma can also lead people to try to hide mental illness from others. It discourages individuals and their families from getting the help they need due to ‘the fear of being labelled as having a mental health problem’ and fear of discrimination.² This issue was touched on in Chapter 4 in the context of the low rate of help seeking among young people with emerging mental health issues.

5.1.2 Stigma persists

The Committee heard that stigma is a central issue affecting people with mental illness in employment.

Participants suggested that increased awareness and understanding of mental illness has been achieved in relation to depression.³ For example, *beyondblue’s* depression monitor shows that understanding and awareness of depression has increased over the past decade.⁴ More people now identify depression as a major health issue while there has also been some improvement in perceptions of people with depression.

However, understanding and awareness of mental illness such as psychosis remains particularly low. Mr Jeff Galvin, a peer educator with Social Firms Australia (SoFA), told the Committee that:

There is a knowledge gap out in society. Hopefully most of the world knows that schizophrenia is not split personality. We have got that far. But if you use the term ‘psychotic’, there is misunderstanding out there, and this is among educated people. It is not just everybody on the street; it is people who really should know better.⁵

This issue was also identified in the House of Representatives Standing Committee on Education and Employment Inquiry into Mental Health and Workforce Participation (the ‘Federal Inquiry’). The Federal Inquiry stated in its report that:

It is fair to say that there is an increased understanding in the community about common mental illnesses ... 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.⁶

Negative attitudes and perceptions about people with psychosis remain widespread. Research shows that Australians are more likely to endorse stigmatising statements about schizophrenia than other forms of mental illness.⁷

FINDING 1

That despite improvement in public awareness and understanding of depression, negative perceptions and stereotypes of people with severe mental illness such as psychosis are widespread.

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- 2 McDaid, D. (2008) *Countering the stigmatisation and discrimination of people with mental health problems in Europe*, report for the European Commission, p.2.
 - 3 *Transcript of evidence 11*, Professor David Castle—Chair of Psychiatry, St Vincent’s Hospital Melbourne, 24 February 2012, p.7.
 - 4 *Beyondblue, Monitoring awareness of depression: the beyondblue depression monitor*, Media release, 14 November 2008.
 - 5 *Transcript of evidence 15*, Social Firms Australia, 28 February 2012, p.8.
 - 6 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*. Canberra, Parliament of the Commonwealth of Australia, p.33.
 - 7 Reavley, N.J. & Jorm, A., F. (2011) ‘Stigmatizing attitudes towards people with mental disorders: Findings from an Australian national survey of mental health literacy and stigma’. *Australian and New Zealand Journal of Psychiatry*, Vol. 45, pp.1086-93, p.1087.

Employment and perceptions of people with mental illness

The Committee found that improvements in awareness and understanding of mental illness in the broader community are not reflected in the context of the workplace. Groups representing people with mental illness identified that negative perceptions and attitudes towards the employment of people with mental illness remain a major barrier to workforce participation.

GROW is a peer support service for people with mental illness. One of its members told the Committee that:

There is increased awareness, but by the same token it has not in my experience necessarily decreased the stigma associated with it. It has just made more people aware of the fact that there are mental health issues out there. It has not necessarily decreased the stigma at an employer level.⁸

Ms Ingrid Ozols, Managing Director of Mental Health @ Work, also suggested a gap between improved awareness in the community and a general reluctance to employ people with mental illness. Ms Ozols stated that:

I also sense that there is a shift, that we are more aware but that the awareness does not mean that it is articulated into behaviour change and culture change. It is sort of a double-edged sword. We have still got a fair bit of work to do to actually bring the change to a behavioural change level. That is where we are referring to people being employed. That is one example. We might be more aware, but does it mean we are employing more people with mental health issues?⁹

The Committee heard that employers can hold a view that there are additional risks and costs involved in recruiting workers with mental illness. For example, *beyondblue* stated that ‘employers are reluctant to employ someone with a mental illness as there is a view that the employee will pose a risk to the organisation and be a potential cost or liability.’¹⁰

The Australian Human Resources Institute (AHRI) informed the Committee that some employers are concerned about the potential that employing someone with mental illness might have for their obligations under occupational health and safety, equal opportunity and fair work laws. Mr Serge Sardo, AHRI’s Chief Executive Officer, explained that:

People are really anxious about the ramifications of breaching such acts—OH&S, the discrimination act, unfair dismissal and those sorts of things. There is a real concern around, ‘If I employ somebody with a mental illness and they do not work out, what are my choices?’ The general perception is that the choices are not very good in terms of being stuck with someone.¹¹

AHRI reported results to the Committee from a survey it undertook in 2011 of 700 members. The survey asked those at the front line of recruitment about workplace attitudes towards people with disability and mental illness:

- 44 per cent of those surveyed said that there was a perception that people with mental illness were not as good performers as people without mental illness.

⁸ *Transcript of evidence 2*, GROW, 4 November 2011, p.8.

⁹ *Transcript of evidence 19*, Mental Health @ Work, 7 March 2012, p.7.

¹⁰ *Submission 19*, *beyondblue*, p.6.

¹¹ *Transcript of evidence 9*, Australian Human Resources Institute (AHRI), 21 November 2011, pp.2-3.

- 48 per cent said there was also a perception that people with mental illness posed a higher risk to businesses.
- Almost half said that these negative perceptions translated into organisations choosing not to employ people with mental illness.¹²

Research studies suggest some employers may also be apprehensive that other staff will react negatively to the employment of someone with mental illness, and in some cases that this would lead to broader organisational performance issues.¹³

FINDING 2

That perceptions and attitudes toward people with mental illness in the workforce have not improved to the same extent achieved in the broader community.

5.1.3 Stigma and non-disclosure

The Committee identified that stigma associated with mental illness in employment can lead many people to keep their mental illness hidden from employers and co-workers. For example, Orygen Youth Health told the Committee that as many as 95 per cent of young people with psychosis participating in its employment programs choose not to disclose their mental illness.¹⁴

Several participants acknowledged the high profile business people, politicians, and sports stars who have publicly disclosed mental illness. They made the point that the majority of workers are not so well placed to risk the consequences of openly disclosing mental illness. Ms Maria Katsonis, Co-Convenor of Open Minds, explained:

We have gone reasonably far from where we were five years ago in relation to stigma. People like Geoff Gallop and others have come out very publicly—sports stars et cetera—but I think in the ordinary office environment it is very different.¹⁵

Many Inquiry participants were of the view that non-disclosure can hinder the successful employment of people with mental illness. The Committee heard that when people with mental illness do not disclose they have a health condition it can mean that employers are unaware of any adjustments needed to support the person. Open Minds explained that:

Disclosure is necessary if access is needed to appropriate workplace support and adjustments. Without these supports, employees can struggle with work duties and this can lead to perceptions of poor work performance. Not disclosing can also lead to isolation which is compounded by the invisibility of mental illness.¹⁶

¹² *Transcript of evidence 9*, Australian Human Resources Institute (AHRI), p.2.

¹³ Two thirds of employers interviewed by the Department of Education, Employment and Workplace Relations in its 2008 study expressed concern about how other employees would react to the recruitment of someone with mental illness. See Department of Education, Employment and Workplace Relations (2008) *Employer attitudes towards employing people with mental illness*. Canberra, Department of Education, Employment and Workplace Relations, Commonwealth of Australia, p.33. Similarly, more than half of employers surveyed in 2009 by the United Kingdom charity Shaw Trust said that negative attitudes from co-workers were a major barrier to employing people with mental illness. Shaw Trust (2010) *Mental health: Still the last workplace taboo?*, London, Shaw Trust, p.24.

¹⁴ *Submission 18*, Orygen Youth Health, p.5.

¹⁵ *Transcript of evidence 8*, Open Minds, 21 November 2011, p.4.

¹⁶ *Submission 16*, Open Minds, p.7.

In its submission, SANE included the results of a 2006 survey that it carried out among people with mental illness regarding their experience of barriers to employment. The majority (67 per cent) of those who had disclosed their mental illness said that ‘disclosing had been helpful because it provided a more understanding work environment, made getting support easier, and meant that they were less worried at work.’¹⁷

Some participants suggested that disclosure can also help to challenge negative perceptions of people with mental illness in the workplace. Mr Sardo from AHRI explained that disclosure ‘normalises the fact that some people have a mental illness and that is okay and they can come to work.’¹⁸ Open Minds similarly stated that ‘an employee’s act of disclosure ... can help counter negative stereotypes and perceptions by demonstrating that people with mental illness are able to work.’¹⁹

Significantly, in its review of the literature on anti-stigma initiatives, the Queensland Alliance noted that ‘direct contact is consistently identified as the most effective means of producing long-lasting and sustained improvement in public attitudes.’ It went on to state that:

Given the high prevalence of mental health problems within the population ... we are in constant contact with people who have mental health problems. What is missing is disclosure.²⁰

The Committee identified that the issue of disclosure is complex and that it is important to consider disclosure along a continuum. For example, people with mental illness may not need to disclose the nature of their illness, but they do have an obligation to disclose if their health condition affects their capacity to fulfil the requirements of their job. On this point, Ms Laura Collister, General Manager of Rehabilitation Services at the Mental Illness Fellowship of Victoria (MI Fellowship), explained that:

Sometimes disclosing enough might be saying, ‘You know what? I take medication so I am quite sleepy in the morning. Therefore, can I start at 10 o’clock rather than 9 o’clock?’ That may be the level of disclosure that is going to create the accommodation to make it worthwhile. Sometimes it is saying, ‘I have a mental illness, and at times I need to go to a doctor’, versus the full disclosure of saying, ‘I have schizophrenia and this has meant, A, B, C.’ We work with individuals to see it as a continuum and what they are comfortable with, because I think it is a good thing.²¹

In considering factors that contribute to disclosure and non-disclosure, the Committee identified that workplace culture and the level of understanding and awareness of mental illness by colleagues and employers are critical in influencing people’s decisions regarding disclosure. The Committee recognises that fostering positive workplace cultures requires providing assistance to employers in understanding how to manage and supporting employees with mental illness. This issue is discussed further in Chapter 6.

17 Survey reported in *Submission 7*, SANE, p.4. See also SANE (2006) *Research bulletin 3: Employment and mental illness*. Melbourne, SANE, p.2.

18 *Transcript of evidence 9*, Australian Human Resources Institute (AHRI), p.4.

19 *Submission 16*, Open Minds, p.7.

20 Queensland Alliance for Mental Health (2010) *From discrimination to social inclusion: A review of the literature on anti-stigma initiatives in mental health*. Fortitude Valley, Queensland, Queensland Alliance for Mental Health, p.18.

21 *Transcript of evidence 25*, Mental Illness Fellowship of Victoria, 7 March 2012, p.6.

Inquiry participants suggested that positive work culture and understanding of mental illness in the workplace can be fostered through workplace mental health literacy training programs. These programs are further discussed in Chapter 6, Section 6.3.3. They provide training to managers, human resources and general staff on how to recognise, respond to and support someone with mental illness in the workplace. Many also include modules outlining the diversity of mental illness and challenging myths and misconceptions related to people with mental illness in the workforce.

In its submission, Mission Australia suggested that ‘such interventions can have a powerful role to play in supporting employees to seek support if required and to remain engaged in employment.’²² Similarly, Open Minds stated that ‘an employee with mental illness is more likely to disclose when the workplace culture is supportive and there is tangible evidence of mental health literacy.’²³ Open Minds went on to suggest that tangible evidence of mental health literacy could be provided through:

- having mental health specific return to work policies and guidelines (see Chapter 7)
- participating in events such as Mental Health Week and *R U OK? Day*
- holding mental health awareness seminars and resources
- incorporating mental health into organisation wide well-being strategies.²⁴

FINDING 3

That disclosure can be important in the successful employment of people with mental illness.

FINDING 4

That fear of stigma can lead people to keep their mental illness hidden within the workplace.

FINDING 5

That disclosure of mental illness by employees can contribute to improved perceptions of people with mental illness in the workplace.

5.2 Changing perceptions

Changing perceptions about people with mental illness is critical in fostering their employment.

The Committee recognises that over the past decade efforts have been made to increase understanding of mental illness in the broader community and to challenge stigma. In particular, *beyondblue* has campaigned extensively in the broader media to raise awareness of depression and anxiety as significant health issues. It has also encouraged help seeking and the delivery of programs targeted to particular settings such as workplaces and schools.

²² Submission 29, Mission Australia, p.17.

²³ Submission 16, Open Minds, p.7.

²⁴ Submission 16, Open Minds, p.7.

Inquiry participants explained that while broad community education has contributed to increased understanding of mental illness generally, there needs to be a specific emphasis on challenging perceptions of mental illness in the workplace.²⁵

The Committee determined that a multi-pronged strategy is needed to change perceptions and to improve responses to people with mental illness in the workplace by employers. There was overwhelming support among Inquiry participants for such a strategy.²⁶

Witnesses in the Federal Inquiry similarly called for a broad anti-stigma strategy to change perceptions and challenge discrimination against people with mental illness. The key recommendation of the Federal Inquiry's report recommended 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.²⁷

The Committee considered that a complementary Victorian strategy is needed to specifically address issues relating to perceptions of mental illness in Victorian workplaces. It identified that this strategy needs to focus on perceptions of the employment of people with mental illness and improving responses in workplaces. Through its investigations, the Committee identified that targeted campaigns aimed at countering stigma and discrimination among particular groups, such as employers, are more effective than general campaigns directed at the broader public.²⁸

Participants suggested that a stigma reduction strategy should include community awareness raising initiatives to promote the benefits of employing workers with mental illness, and to challenge myths and misconceptions related to the employment of people with mental illness. Participants also identified benefits in incorporating practical education and training programs for employers on managing mental health issues in the workplace as part of a multi-pronged approach.

The Committee identified emerging policy development frameworks that use insights from social and cognitive psychology and behavioural economics to extend beyond awareness raising to actually change people's behaviour through public policy.

One such framework is MINDSPACE.²⁹ This framework was developed by the Institute for Government for the United Kingdom (UK) Government Cabinet Office in 2009. It identifies a number of drivers of behaviour, some of which could be used in the development of a Victorian Government strategy to improve responses to people with mental illness in workplaces. These are outlined in Table 5.1.

25 *Transcript of evidence 3*, Geelong and Region Trades Hall and Labour Council, 4 November 2011, pp.5-8.

26 For example, see *Transcript of evidence 3*, Geelong and Region Trades Hall and Labour Council, p.5.

27 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.xvii.

28 McDaid (2008) *Countering the stigmatisation and discrimination of people with mental health problems in Europe*, pp.12-13.

29 Dolan, P., Hallsworth, M., Halpern, D. et al. (2009) *MINDSPACE: Influencing behaviour through public policy*. London, United Kingdom Government Cabinet Office and Institute for Government.

Table 5.1: MINDSPACE Framework

Influence	Description	Possible application
Messenger	<ul style="list-style-type: none"> We are heavily influenced by who communicates information and who it is intended for. Demographic and behavioural similarities between the messenger and the recipient can improve the effectiveness of communication. 	<ul style="list-style-type: none"> Campaigns featuring, or delivered by, 'real people' living with mental illness or by employers who have had experience working with people with mental illness may be more effective than campaigns featuring celebrities and high-profile figures. It is important to portray experiences of people with mental illness from varied economic, social and cultural backgrounds.³⁰
Norms	<ul style="list-style-type: none"> We are strongly influenced by what others do. For example, hotel guests are more likely to re-use their towels if told that other guests recycle their towels than if asked to consider the environment.³¹ 	<ul style="list-style-type: none"> Highlighting examples of prominent employers that employ people with mental illness may convince other employers to do the same.
Salience	<ul style="list-style-type: none"> People are more likely to register novel, simple and accessible messages. People are more likely to understand information that is presented in ways that relate directly to their experiences. 	<ul style="list-style-type: none"> Campaigns to counter stigma and discrimination need to focus on conveying a simple message such as people with mental illness are effective employees when flexibility can be achieved in the workplace. People in different work roles bring different perspectives and concerns to the employment of people with mental illness. Employers, human resource (HR) consultants and employees may need to be engaged in different ways.
Affect	<ul style="list-style-type: none"> Emotional responses to words, images and events have a powerful influence on the way people act. 	<ul style="list-style-type: none"> Personal stories targeted at changing the heart not just the mind of the audience may be central to addressing stigma.³²
Commitment	<ul style="list-style-type: none"> We seek to be consistent with our public promises and reciprocate acts. 	<ul style="list-style-type: none"> Encouraging individuals/organisations to pledge that they will avoid discriminating against people with mental illness may encourage them to respond more positively to people with mental illness. For example, SANE encourages organisations to sign up to a Mindful Employer Charter.

Source: Compiled by Family and Community Development Committee.

30 Neasa Martin & Associates (2007) *A time for action: Tackling stigma and discrimination—A report to the Mental Health Commission of Canada*. Toronto, Mental Health Commission of Canada, p.21.

31 Dolan, Hallsworth, Halpern et al. (2009) *MINDSPACE: Influencing behaviour through public policy*, p.22.

32 Neasa Martin & Associates (2007) *A time for action: Tackling stigma and discrimination—A report to the Mental Health Commission of Canada*, p.21.

→ RECOMMENDATION 5.1:

That the Victorian Government develops and implements a targeted multi-pronged campaign to reduce stigma associated with employment by people with mental illness through:

- Community education and awareness to promote positive perceptions of the employment of people with mental illness.
- A program for employers with positive experiences to champion the employment of people with mental illness.
- Providing practical guidance and support to employers in relation to recruiting and retaining employees with mental illness.

5.2.1 Increasing awareness and education

The Committee identified that targeted education and awareness-raising is essential to changing perceptions of people with mental illness in workplaces. Achieving greater awareness will enhance opportunities to participate in employment. Many Inquiry participants expressed this view. For example, Jesuit Social Services (JSS) stated that ‘a community education campaign that emphasises the importance of social inclusion is required to address discrimination in the workplace.’³³ Similarly, the Victorian Branch of the Australian Medical Association (AMA) told the Committee that:

The role of Government in fostering awareness and educational initiatives is critically important and should include ongoing public awareness campaigns to improve community understanding of mental health issues and reduce the stigma associated with mental health problems.³⁴

Evidence shows that education and awareness can improve attitudes toward people with mental illness. However, the type of information provided in campaigns and how it is conveyed are critical. For example, research suggests that education has the greatest resonance when the information provided builds understanding of the human experience of living with mental illness and when ‘it is targeted, segmented, delivered locally and the messages are audience-specific.’³⁵

Community awareness campaigns

Community awareness campaigns often consist of intensive communications using a broad range of media including television, radio and newsprint advertisements as well as posters and public announcements, coupled with targeted communication to particular groups such as employers.

There was broad support among Inquiry participants for a community awareness campaign specifically targeted at employers to promote the benefits of employing workers with mental illness and to challenge common myths and misconceptions related to the employment of people with mental illness.

³³ Submission 39, Jesuit Social Services, p.4.

³⁴ Submission 34, Australian Medical Association (AMA) Victoria, p.2.

³⁵ Queensland Alliance for Mental Health (2010) *From discrimination to social inclusion: A review of the literature on anti-stigma initiatives in mental health*, p.19.

A number of Inquiry participants suggested that a multi media campaign along the lines of recent WorkSafe campaigns is needed to challenge negative perceptions of people with mental illness in employment. For example, Prahran Mission stated that:

The main employer issue faced by people with a mental illness is the employer's lack of awareness of the nature of mental illness and preconceived notions of what mental illness is. This negative bias greatly affects the potential for employers to engage people with mental illness in work ...

A media campaign on the scale of the WorkSafe campaign would certainly raise employer and general public awareness of the nature of mental illness.³⁶

Similarly, VincentCare expressed the view that:

The approach taken by the Victorian WorkCover Authority with its recent return to work and safety campaigns is an example of a public messaging campaign which might be able to be transferred in its broad concept to a publicity messaging campaign focusing on mental health and employment.³⁷

The Committee determined that a community awareness campaign could include media advertising as well as more localised ways of engaging with relevant stakeholders such as forums organised by local government, industry associations, unions, and employer groups. It identified that the campaign would benefit from a targeted approach with a strong message about:

- the business and community benefits of employing workers with mental illness
- the diversity of people with mental illness and their positive contribution to the workforce.

In this vein, Mr Paul Begley, National Manager of Government and Media Relations at AHRI, told the Committee that more needs to be done to 'market' the employment of people with mental illness to employers. He explained that:

When [AHRI members] try to put a business case or try to advocate for the employment of a person with a mental illness they really do not get anywhere. There is no knowledge that this is an issue.³⁸

Several participants also stressed the importance of highlighting that many people with mental illness are already in employment and that most businesses probably employ someone with undisclosed mental illness. As Ms Sally Gibson, Co-Convenor of Open Minds, told the Committee:

Whether people like it or not, they are dealing with mental illness in the workplace all the time ... Everyone in their lifetime is probably susceptible to a mental illness of one degree or another.³⁹

The Committee noted that this has been the approach taken by Australian Employers' Network on Disability in communicating the value to business of recruiting workers with disability (including mental illness). Box 5.1 provides an overview of *Opportunity*, a booklet developed by the Australian Employers' Network on Disability to encourage more employers to recruit workers with disability.

36 *Submission 15*, Prahran Mission UnitingCare, p.7.

37 *Submission 28*, VincentCare Victoria, p.11.

38 *Transcript of evidence 9*, Australian Human Resources Institute (AHRI), pp.6-7.

39 *Transcript of evidence 8*, Open Minds, p.8.

Box 5.1 Opportunity

Opportunity is a booklet that was developed to clearly articulate the relevance of people with disability to Australian businesses.

It was developed by the Australian Employers' Network on Disability in 2008, with the support of the Commonwealth Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA); the New South Wales (NSW) Department of Ageing, Disability and Home Care; and a number of major employers.

The booklet included cases studies of major employers that had successfully employed people with disability as well as people with disability successfully employed in law firms, the finance sector, and major multinational IT companies.

It also emphasised that:

- Leading organisations such as Westpac, McDonald's, IBM, and KPMG are already welcoming skilled and talented people with disability and reaping the rewards.
- There are already many people with disability successfully employed in the Australian workforce, and more than a third are employed in professional, managerial and administrator roles.
- Workers with disability are no more likely to be injured at work than other employees and there are no differences in performance and productivity between workers with disability and other workers.
- On average, employing people with disability does not cost any more than employing people without disability.

Source: Compiled by Family and Community Development Committee

In considering the role of awareness raising in changing perceptions, the Committee determined that campaigns need to be used in connection with other strategies and not in isolation. Although evidence indicates that awareness campaigns can achieve some change in attitudes, positive shifts in attitude alone may not always lead to changes in behaviour towards people with mental illness.⁴⁰ In particular, the Committee heard that it is critical to provide practical training and support to employers to equip them with the skills and resources to recruit and retain workers with mental illness. This issue is discussed in greater detail in Chapter 6.

FINDING 6

That a targeted awareness-raising campaign used in conjunction with other strategies can be effective in promoting positive perceptions of the employment of people with mental illness.

→ RECOMMENDATION 5.2:

That the Victorian Government develops a targeted awareness campaign with relevant stakeholders to challenge perceptions of people with mental illness and improve responses in workplaces using multi-media and promotion tools in conjunction with other strategies.

40 Queensland Alliance for Mental Health (2010) *From discrimination to social inclusion: A review of the literature on anti-stigma initiatives in mental health*, p.19.

Community education

In addition to an awareness campaign, the Committee considered that community education has a role in changing perceptions of people with mental illness in the workforce.

Community education can take many forms such as educational conferences, workshops, forums and multi-media resources explaining the benefits of employing people with mental illness and the experiences of people with mental illness in the workforce. Importantly, studies of the effectiveness of community education in changing perceptions suggest that community education works best when it is:

- multi-faceted and includes confronting common myths
- segmented, delivered locally and the messages are audience-specific
- delivered by people with lived experience of mental illness.⁴¹
- Inquiry participants informed the Committee about innovative community education initiatives in Victoria. For example, several participants in the Inquiry cited the *R U OK? Day* initiative.⁴² This initiative is considered an effective approach to community awareness raising that could be built on to improve responses to people with mental illness in workplaces.

Box 5.2 *R U OK Day?*

R U OK? Day is a national day of action on suicide prevention in which Australians are encouraged to connect with family, friends, and colleagues and talk about any mental health concerns. Workplaces, schools, universities and sports clubs are targeted to participate in the national day of action.⁴³

Ms Christine Couzens, President of the Geelong and Region Trades Hall and Labour Council (GRTHLC), told the Committee that *R U OK Day?* had 'turned out to be a very positive community education and awareness project' in the region.⁴⁴ The initiative was promoted to employers in the region by the Chamber of Commerce, industry associations, and unions. Ms Couzens said that the feedback from employers was that '*R U OK? Day* was a great awareness toll that should be expanded.'⁴⁵

Source: Compiled by Family and Community Development Committee.

The Committee heard that it is important that community education programs are appropriately tailored to those at different levels within organisations. For example, Inquiry participants suggested:

Dedicated resources and training for managers and supervisors, because they are at the front line and are the linchpin between the employers, the employee and often between HR [human resources] and OHS [occupational health and safety] practitioners.⁴⁶

41 Queensland Alliance for Mental Health (2010) *From discrimination to social inclusion: A review of the literature on anti-stigma initiatives in mental health*, p.19.

42 *Transcript of evidence 3*, Geelong and Region Trades Hall and Labour Council, p.2; *Transcript of evidence 8*, Open Minds, p.4.

43 R U OK? (2012). *What is R U OK? Day?* Accessed on 27 June 2012 from <http://www.ruokday.com.au/content/what-is-ruokday.aspx>.

44 *Transcript of evidence 3*, Geelong and Region Trades Hall and Labour Council, p.6.

45 *Transcript of evidence 3*, Geelong and Region Trades Hall and Labour Council, p.2.

46 *Transcript of evidence 8*, Open Minds, p.5.

Other participants emphasised the importance of targeting HR consultants as critical gatekeepers in the recruitment and employment process.⁴⁷

Many Inquiry participants highlighted the benefits of targeted mental health literacy training programs within workplaces in changing perceptions and improving responses to people with mental illness in workplaces.⁴⁸ These programs are discussed in further detail in Chapter 6, Section 6.3.3. The Committee determined that mental health literacy training programs that up-skill managers, HR staff, and employers in strategies to recruit and retain employees with mental illness are critical to changing behaviours towards the employment of people with mental illness (see Recommendation 6.5).

FINDING 7

That community education programs that individually target managers, supervisors, human resources staff, and general staff can contribute to changing perceptions of people with mental illness in employment.

5.2.2 Practical supports for employers

In evidence to the Inquiry, participants emphasised the need to provide practical guidance and support to employers if behaviours toward the employment of people with mental illness are to change. For example, the Recruitment and Consulting Services Association (RCSA) suggested directing resources:

To the provision of services to employers that directly assist in forming employment and recruitment strategies and policy and directly preparing a workplace to increase workforce participation for workers with a mental illness.⁴⁹

In its submission, JSS similarly identified that:

More needs to be done to educate employers about supporting employees with mental illness in relation to their health and their career. Financial incentives, training programs, support services and mentoring programs for employers and greater community education are all required to address this important issue.⁵⁰

As discussed further in Chapter 6, the Committee heard that providing practical support to employers in recruiting and retaining workers with mental illness is crucial to enhancing opportunities for workforce participation by people with mental illness.

Inquiry participants told the Committee that many employers would be willing to employ people with mental illness if they had greater support in understanding how to manage mental health issues in the workplace. In particular, participants identified that employers may be unfamiliar with how to provide flexible work arrangements and adjustments to support employees with mental illness.

VEOHRC identified that different types of mental illness and the varying support requirements 'can make it difficult for employers to have the knowledge and confidence to assist employees in the workplace.'⁵¹ Mr Sardo from AHRI suggested that employers feel less confident about employing people with mental illness than

47 *Transcript of evidence 12*, EACH Employment, 24 February 2012, p.6.

48 *Submission 26*, Victorian Mental Health Carers Network, p.4.

49 *Submission 22*, Recruitment and Consulting Services Association (RCSA), p.10.

50 *Submission 39*, Jesuit Social Services, p.6.

51 *Submission 41*, Victorian Equal Opportunity and Human Rights Commission, p.4.

they do about hiring workers with physical disability. He explained that ‘a physical disability is one you can see and you can often ergonomically strategise/get around it, whereas a mental illness is a real enigma for many employers.’⁵²

Chapter 6 considers strategies to support employers in providing flexible work options in greater detail, including information and advice services, guidebooks, and workplace mental health literacy training programs.

FINDING 8

That practical support and information for employers in managing employees with mental illness is an essential part of any campaign to improve responses to people with mental illness in employment.

5.3 Employer champions

Research evidence suggests that people are strongly influenced by the behaviour of others, ‘particularly by those who are similar to themselves’.⁵³ The concept of employer champions is increasingly popular as a strategy for promoting positive responses among employers to the employment of people with mental illness. Employer champions in this context are businesses that showcase their experiences in employing workers with mental illness with a view to changing perceptions and approaches among their peers to employing people with mental illness.

The Committee heard that there is significant value in leading employers championing employment of people with mental illness. Inquiry participants suggested this approach can potentially achieve wider behaviour change in the business community towards the employment of people with mental illness. For example, a number of Australia’s larger employers, such as NAB, BHP and ANZ, have led the way in employing people with disability (including people with mental illness).⁵⁴

The Committee determined that an education and awareness raising campaign could benefit from showcasing the positive experiences of organisations in recruiting and retaining workers with mental illness. Mr Sardo from AHRI drew a parallel between the need for organisations to champion the employment of people with mental illness and the momentum gathering to increase the representation of women in senior executive roles:

ASX has just put out their diversity principles; they recommended reporting on targets and things like that. Disability gets no mention whatsoever, which is really interesting ... We ran a gender equity summit about women on boards not long ago. We had everybody wanting to attend at a very senior level ... There is a real issue here about stakeholders, champions and employer groups really getting on top of this issue and not just tackling the sexy issues.⁵⁵

The Federal Inquiry highlighted the positive initiatives that a number of private sector employers, including Abigroup Inc. and Rio Tinto, have implemented to raise

52 *Transcript of evidence 9*, Australian Human Resources Institute (AHRI), p.3.

53 Dolan, Hallsworth, Halpern et al. (2009) *MINDSPACE: Influencing behaviour through public policy*, p.31.

54 *Transcript of evidence 20*, Recruitment and Consulting Services Association (RCSA), 7 March 2012, p.5; *Transcript of evidence 12*, EACH Employment, p.9. See glossary for clarification of the term disability and how it is used in the context of people with mental illness.

55 *Transcript of evidence 9*, Australian Human Resources Institute (AHRI), p.6.

awareness of mental health issues in the workplace and support the recruitment and retention of employees experiencing mental health issues. These businesses indicated to the Federal Inquiry that they would be willing to share aspects of their own experiences and successes to other organisations.⁵⁶

5.3.1 Involving local employers

The Committee considered that it is important to also involve small and medium sized enterprises at a local level in championing the employment of people with mental illness. For example, Mr Simon Schweigert, Project Manager with RCSA, suggested it would be valuable engaging small and medium sized enterprises to provide community leadership and advocacy in relation to the employment of people with mental illness.⁵⁷ He explained that it is not widely known that many small and medium sized enterprises currently employ people with mental illness in their business.

Mr Schweigert suggested that showcasing the experiences of these businesses through community forums facilitated by local government could help to normalise the employment of people with mental illness at a grassroots level and encourage other local businesses to consider employing workers with mental illness:

They are really great people doing really great work and employers who are just waiting to be advocates. One other message I receive from the employers is, 'We want to tell our story, but we need some platforms to be able to do that.' We go through the whole award process ... We win an award here, and we win an award there, but we want to do more. Someone described it to me like this: 'We are sitting in neutral, and we want to get going.' We see it as being able to build a voice and a national conversation at the grassroots level and at a community level, remember that 50 per cent of employers are small to medium businesses.⁵⁸

RCSA recommended that government partner with industry associations to facilitate local exchanges with employers to promote and develop strategies for employing workers with mental illness.⁵⁹

RCSA gave the example of seminar series and symposiums that it had previously organised between employers and employment agencies to promote inclusive employment practices in relation to people with disabilities and mature age workers.⁶⁰ It was suggested that a similar style of approach could be used to promote the benefits of employing workers with mental illness to small and medium sized enterprises. Mr Sardo from AHRI expressed a similar view. He explained that 'between the various professional associations ... [there is] a really good reach of employer groups that could be utilised.'⁶¹ He pointed out that AHRI alone has access to 18,000 members nationally.

56 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.153.

57 *Transcript of evidence 20*, Recruitment and Consulting Services Association (RCSA), p.5.

58 *Transcript of evidence 20*, Recruitment and Consulting Services Association (RCSA), p.5.

59 *Transcript of evidence 20*, Recruitment and Consulting Services Association (RCSA), p.5, p.7.

60 *Submission 22*, Recruitment and Consulting Services Association (RCSA), p.7.

61 *Transcript of evidence 9*, Australian Human Resources Institute (AHRI), p.7.

FINDING 9

That local government and industry associations have a key role in showcasing the positive experiences of major and local employers in recruiting and retaining workers with mental illness.

→ RECOMMENDATION 5.3:

That the Victorian Government works with relevant stakeholders to foster opportunities for employers to showcase positive experiences in recruiting and retaining workers with mental illness.

5.3.2 Increasing public sector employment of people with mental illness

Many Inquiry participants expressed the view that government can contribute to broader cultural change through championing the employment of people with mental illness. The Committee, however, heard that existing rates of public sector employment of people with mental illness are low. In considering the importance of lead employers championing the employment of people with mental illness, the Committee identified a need to increase public sector employment of people with mental illness.

Mr Sardo from AHRI told the Committee that the public sector is not a leader in implementing socially inclusive employment strategies. He stated that:

It is a little bit disheartening to see that targets, even within the public sector, have gone backwards on disability employment [employees who self-identify as having mental illness are included within estimates of public sector employment of people with disability].⁶²

In June 2012, the Australian Public Service (APS) Disability Employment Strategy reported that only three per cent of ongoing employees in the APS have a disability or mental illness. Moreover, representation of people with disability in the APS has been in decline since the late 1990s, when around five per cent of APS employees reported disability.⁶³

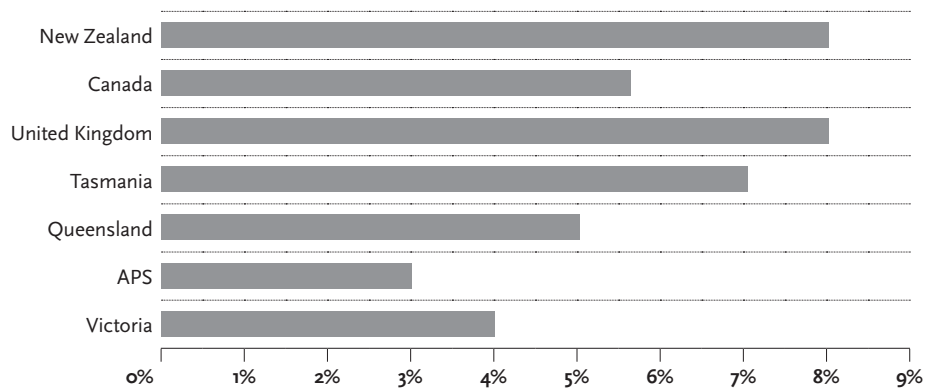
The representation of people with disability (including mental illness) in the Victorian Public Service is marginally higher, with people with disability representing four per cent of the Victorian public sector workforce in June 2011.⁶⁴ This representation rate is low by international standards and also compared with some Australian states such as Queensland and Tasmania.

⁶² *Transcript of evidence 9*, Australian Human Resources Institute (AHRI), p.5.

⁶³ Australian Public Service Commission (2012) *As one: Australian public service disability employment strategy*. Canberra, Australian Public Service Commission, Commonwealth of Australia, pp.21-23.

⁶⁴ State Services Authority (2012) *The state of the public sector in Victoria 2010-11*. Melbourne, State Government of Victoria State Services Authority, p.9.

Figure 5.1: Public sector employment of people with disability (including mental illness) in selected countries and jurisdictions



Source: Australian Public Service Commission (2012), *Australian public service disability employment strategy*. Canberra, Australian Public Service Commission, Commonwealth of Australia, pp. 22-23.

Inquiry participants called on the Victorian and local governments to increase recruitment and retention rates of people with mental illness. SANE commented that:

Employers need encouragement and incentives to provide flexible work arrangements ... The Victorian Government can lead by example through its own employment practices for the public service, and by the contracting of services to organisations which provide employment for people with a mental illness ...⁶⁵

VincentCare also stated that:

State and local governments themselves are in an opportune position to set the standard as good employers and to ensure their own practices 'walk the talk.' This means that state and local government need to consider measures such as setting their own targets for providing employment opportunities for people with mental health problems. State and local government can also develop policies and guidelines which, tested in the local and state government setting, can be transferred into the non-government sector.⁶⁶

The Committee noted the proactive approach towards the recruitment and retention of people with mental health problems that has been taken by some Victorian Government agencies and statutory organisations. Box 5.3 outlines the approach of the Victorian Transport Accident Commission (TAC) in developing employment practices that are inclusive of people with mental illness.

⁶⁵ Submission 7, SANE, p.1.

⁶⁶ Submission 28, VincentCare Victoria, p.12.

Box 5.3 The Victorian Transport Accident Commission (TAC)

During the Inquiry, the Committee heard from the TAC. In 2009, following relocation to Geelong, TAC developed a diversity and inclusion strategy and made mental health a priority of the strategy. Ms Janet Dore, Chief Executive Officer of TAC, told the Committee that TAC's vision is 'to develop a workforce that is as diverse as the community.'⁶⁷ As she explained, 'it makes sense for us to understand that, like the general population, our staff sometimes have issues. It does not detract from their value to us.'⁶⁸

To this end, TAC has implemented a number of initiatives to support the recruitment and retention of people with mental health issues, including:

- creating a work environment where people can be open and comfortable in dealing with mental health issues
- providing flexible work arrangements
- educating managers on how to support employees with mental health issues in their team environment
- an Employee Assistance Program (EAP), with round-the-clock support for employees who wish to access it.

TAC identified a number of tangible benefits from providing such support to employees with mental health issues:

- 77 employees, or 9 per cent of TAC's workforce as at January 2012, have disclosed mental illness since 2009.
- TAC is seen as an 'employer of choice' and 'best practice employer' by the wider community, improving its ability to recruit quality employees to better serve the needs of its clients.
- Improved workforce planning through the planning for leave required for employees to seek treatment.⁶⁹

Source: Compiled by Family and Community Development Committee

The MI Fellowship told the Committee that the public sector still has a long way to go in promoting the recruitment and retention of people with mental illness. MI Fellowship provides Commonwealth-funded Disability Employment Services (DES) to people with severe mental illness across multiple sites in Victoria. Ms Collister explained that:

We do not have a great deal of success in returning people to government positions or getting people jobs in government departments ... We have much more success working with small businesses that are interested in mental illness, often because of a personal experience that has affected them ... we have much less success working with large government departments.⁷⁰

In its submission, VEOHRC proposed 'an increase in VPS [Victorian Public Service] traineeships and work experience opportunities for people with mental illness.'⁷¹ VEOHRC suggested that this 'could contribute significantly to providing individuals with on the job work experience and increasing their confidence to participate in the workplace.'⁷²

⁶⁷ *Transcript of evidence 23*, Transport Accident Commission (TAC), 7 March 2012, p.5.

⁶⁸ *Transcript of evidence 23*, Transport Accident Commission (TAC), p.5.

⁶⁹ *Supplementary evidence 23A*, Transport Accident Commission (TAC), 7 March 2012, p.17.

⁷⁰ *Transcript of evidence 25*, Mental Illness Fellowship of Victoria, p.5.

⁷¹ *Submission 41*, Victorian Equal Opportunity and Human Rights Commission, p.14.

⁷² *Submission 41*, Victorian Equal Opportunity and Human Rights Commission, p.14.

VEOHRC noted that the Victorian Government currently operates a best practice model disability employment service, the Disability Employment Advisory Service (DEAS). DEAS is delivered by the private recruitment firm, Randstand, in partnership with Diversity@Work, to provide support to:

- jobseekers with disability seeking employment in the VPS
- VPS managers seeking to employ people with disability.

VEOHRC recommended that the Victorian Government continue its funding of DEAS. VEOHRC also suggested that VPS opportunities could be further opened up to people with mental illness through ‘removing requests for information about a potential employee’s medical history from the selection processes.’⁷³

FINDING 10

That the Victorian and local governments can play a leadership role in improving workplace responses to people with mental illness through championing the public sector employment of people with mental illness.

→ RECOMMENDATION 5.4:

That the Victorian Government develops an internal strategy for improving recruitment and retention of people with mental illness and works with local councils to promote the employment of people with mental illness by local government.

⁷³ *Submission 41*, Victorian Equal Opportunity and Human Rights Commission, p.14.

Chapter Six: Providing diverse employment pathways

Findings

1. That people have varied experiences of mental illness that lead to different needs and expectations in relation to employment.

2. That people with mental illness need to be supported to look for work as soon as they are motivated to do so.

3. That motivation can be hindered by lengthy referral and assessment processes for employment support services, which can take up to several months to complete in some cases.

4. That jobseekers with mental illness may benefit from tailored employment programs that:
 - Allow for a gradual increase in working hours.
 - Provide more intensive support following job-placement to assist in managing disclosure of mental illness and negotiating workplace adjustments to cope with declines in symptoms.

5. That providing training and information services to employers in the management of mental health issues in the workplace can assist employers to successfully recruit and retain people with mental illness.

6. That existing information services and incentives to support employers in recruiting and providing flexible work arrangements for people with mental illness need to be more widely advertised.

7. That employers and supervisors may benefit from professional development on workplace adjustments for employees with mental illness and managing the disclosure of mental health issues in the workplace.

8. That social firms are an emerging sector and there is a need for increased evidence to:
 - Determine the sustainability of social firms as commercial businesses.
 - Identify whether people with mental illness employed in social firms transition to sustainable jobs in the open labour market.

This chapter considers the need to ensure a diverse range of flexible employment options are available for people with mental illness.

During the Inquiry, the Committee heard that people's different experiences of mental illness need to be reflected in the design of policies and programs to support workforce participation by people with mental illness.

The Committee heard that existing employment programs can be difficult to access for jobseekers with mental illness and that the support provided is not always appropriate to the employment needs of people with mental illness.

Inquiry participants told the Committee that most people with mental illness want to work in open employment. Yet employers do not always understand how to best manage and accommodate mental health issues within workplaces. The Committee heard that employers require greater assistance and training in how to provide flexible work arrangements for people with mental illness.

Several Inquiry participants highlighted that some people who experience severe symptoms may not be ready, or want, to work in mainstream employment. The Committee heard that these people may require highly flexible employment in a tailored and supportive work environment in order to participate in the workforce. Inquiry participants also identified that, for people who have been unemployed for several years, a period of employment in a supportive working environment can help them to develop the skills, experience, and self-confidence needed to find work in the open labour market.

6.1 Importance of flexible work options

The Committee identified that it is critical to acknowledge difference in people's experience of mental illness when considering policies and programs to support workforce participation by people with mental illness.¹

As discussed in Chapter 1, mental illness includes a broad spectrum of conditions that vary in their nature and impact. Mental illness may also be episodic. As the Mental Health Legal Centre (MHLC) told the Committee, 'the manner and extent to which mental illness will affect a person's employment opportunities or their experiences in the workforce are varied.'² For example, although workforce participation rates are low across the spectrum of mental illness, there are differences in the general patterns of workforce participation between those living with psychotic illness and those with depression and/or anxiety.

Professor Eoin Killackey, Head of the Psychosocial Research Unit at Orygen Youth Health (OYH), told the Committee that whereas people with psychosis can often experience long-term unemployment, 'the sort of employment course for people with depression is very different.'³ He explained that people with depression 'tend to be in and out of employment much more than people with psychosis but they do not tend to get firmly established.'⁴

1 *Submission 19, beyondblue*, p.2; *Transcript of evidence 6*, Psychiatric Disability Services Victoria (VICSERV) & Eastern Regions Mental Health Association (ERMHA), 7 November 2011, p.3.

2 *Submission 40*, Mental Health Legal Centre, p.3.

3 *Transcript of evidence 13*, Orygen Youth Health, 28 February 2012, p.5.

4 *Transcript of evidence 13*, Orygen Youth Health, p.5.

The Committee identified that the diversity of people's experience of mental illness results in different needs and expectations among people with mental illness in relation to employment:

- Many people with mental illness are already working in mainstream employment, though the episodic nature of mental illness and the stigma associated with mental illness can make retaining employment difficult (see Chapter 5, Section 5.1.3). For these people, the main issue is keeping their employment during episodes of symptom exacerbation and quickly returning to work after occasions when they need to take time-off to focus on recovery. This issue is considered in detail in Chapter 7 (see Section 7.5).
- A substantial number of people with mental illness are ready to work in mainstream employment but are unemployed due to:
 - ineffective employment support services
 - the reluctance of some employers to knowingly recruit someone with mental illness because of doubts about managing mental health issues in the workplace
 - limited flexibility of job arrangements within workplaces. For example, people with mental illness may have times when they need flexibility such as being able to reduce their working hours or take additional leave to cover extended work absences.
- Some people with mental illness may not yet be ready to work in mainstream employment for a range of reasons, including:
 - lack of appropriate work skills or qualifications as a consequence of the impact of mental illness on their education and training (see Chapter 4)
 - low self-confidence or limited work experience
 - difficulties managing the symptoms of mental illness in the context of employment.
- People not yet ready to work in open employment may require a gradual return to work in a supportive environment to boost their confidence and skills before taking up an unsupported position in the mainstream labour market.
- A minority of people with severe and enduring mental illness experience symptoms that can be very difficult to accommodate within mainstream work environments. However, the Committee heard that they can still experience social inclusion and the positive influence of employment on their health through working in the supportive environment of a social firm.⁵

The Committee determined that a range of employment options need to be available to people with mental illness to reflect differences in capacity to participate across individuals and during people's working lives. These should include:

- flexible options for participating in competitive (mainstream) employment
- employment options in more supportive working environments that can provide more intensive in-work support (such as peer mentoring, adjustments to the work environment to accommodate difficulties with thinking processes) either on a permanent or transitional basis.

⁵ Submission 28, VincentCare Victoria, p.8.

FINDING 1

That people have varied experiences of mental illness that lead to different needs and expectations in relation to employment.

→ RECOMMENDATION 6.1:

That, as part of a mental health employment strategy (see Recommendation 3.2), the Victorian Government works with relevant stakeholders to ensure a range of flexible employment options that enable people with varied experiences of mental illness to participate in the workforce.

6.2 Employment support services

The Committee heard that the way in which employment support is provided to jobseekers with mental illness can be one of the main barriers preventing people with mental illness from finding sustainable employment.

As discussed in Chapter 3, the Commonwealth Government funds and administers the bulk of employment support services for people with mental illness. These services include Job Services Australia (JSA) and Disability Employment Services (DES). While jobseekers with mental illness can be clients of either JSA or DES, around 30 per cent of all DES clients report having a mental illness as their primary health-related impairment.⁶

Within DES, jobseekers with mental illness can be allocated into different programs depending on the level of support they are assessed as requiring. As the House of Representatives Standing Committee on Education and Employment noted in its Inquiry into mental health and workforce participation (the ‘Federal Inquiry’), these different programs include:

- Disability Management Service—provides help to people with disability, injury or health condition who require the assistance of a disability employment service and are not expected to need long-term or regular support in the workplace.
- Employment Support Service—assists people with permanent disability who are likely to need regular long-term ongoing support in order to retain their job.⁷

6.2.1 Streamlining the assessment process

Jobseekers undergo an assessment process to determine the level of support they need to find and sustain employment.

Using a tool known as the Job Seeker Classification Instrument (JSCI), Centrelink case officers undertake an initial assessment to determine the capacity of jobseekers to work and whether assistance is needed from JSA or DES. Jobseekers who are

6 Minister for Health and Ageing, Minister for Families, Housing, Community Services and Indigenous Affairs, & Minister for Mental Health and Ageing (2011) *Budget 2011-12: National mental health reform—Ministerial statement*. Canberra, Commonwealth of Australia, p.29.

7 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*. Canberra, Parliament of the Commonwealth of Australia, p.162.

initially assessed as having high employment-related support needs are then referred for either an Employment Services Assessment or Job Capacity Assessment. These latter assessments are used to determine eligibility for the Disability Support Pension and to allocate jobseekers into relevant program streams.⁸

Inquiry participants expressed concern about the effectiveness of the assessment process in identifying mental-health related barriers to employment, and the length of time that it can take for assessments to be completed.

OYH told the Committee that ‘it can take in some cases up to two months before any active job searching commences.’⁹ The Committee heard that this conflicts with best-practice in vocational support for people with mental illness, which is to support people to look for work as soon as they are motivated to do so. As OYH explained to the Committee, ‘for young people [with mental illness], if you can get them to be motivated to look for work, you kind of have to strike while the iron is hot.’¹⁰

Ms Laura Collister, General Manager of Rehabilitation Services at the Mental Illness Fellowship of Victoria (MI Fellowship), further elaborated upon the importance of rapidly supporting people to look for work in her evidence to the Committee:

If people say they want to work, we need to get them into a program as soon as possible, and many of you would be aware that the Commonwealth system of people getting employment assistance is a fairly long process and it takes a lot of time ... One of the experiences of people with a mental illness, particularly schizophrenia, is that they lose motivation, they lose hope; they have multiple experiences of failure. If they say, ‘I want to work’, as soon as you say, ‘Yes, but we’re going to put you in A, B and C programs before we start to look for work’, they will drop out of the program.¹¹

FINDING 2

That people with mental illness need to be supported to look for work as soon as they are motivated to do so.

FINDING 3

That motivation can be hindered by lengthy referral and assessment processes for employment support services, which can take up to several months to complete in some cases.

Inquiry participants also expressed concern about the effectiveness of the instrument used in the job capacity assessment process in identifying mental health-related barriers to employment.¹² The Committee heard that mental health service providers have little input into the assessments of their clients. Accurate classification and assessment of clients’ employment support needs therefore often relies on self-disclosure. However, people can be reluctant to disclose their mental illness due to stigma, particularly as initial assessments are often carried out over the phone.¹³

8 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.171.

9 *Transcript of evidence 13*, Orygen Youth Health, p.3.

10 *Transcript of evidence 13*, Orygen Youth Health, p.3.

11 *Transcript of evidence 25*, Mental Illness Fellowship of Victoria, 7 March 2012, p.3.

12 *Submission 29*, Mission Australia, p.14.

13 National Employment Services Association (2011) *Response to the inquiry into mental health and workforce participation*, submission to the House of Representatives Standing Committee on Education and Employment, Parliament of Australia, Inquiry into mental health and workforce participation, p.10.

Another issue is that the episodic nature of mental illness means that its impact on a person's ability to participate in employment can be overlooked if assessment takes place when symptoms are relatively stable. As Prahran Mission told the Committee:

The approach is not holistic in that there is little if any input from the mental health service providers working with a participant. The resulting assessment is not sensitive to the course pattern of illness approach. If the assessment is undertaken at a point in time when the participant is relatively stable health wise, the amount of job seeking support may be underestimated.¹⁴

The Committee came to the view that the structural separation between employment support services and specialist mental health services underlines Inquiry participants' concerns regarding the effectiveness of the assessment process. For example, Associated Professor Carol Harvey from the Psychosocial Research Centre (PRC) explained that:

The lack of integration [between employment support and mental health services] probably contributes to the barriers that have been identified, because the assessments of job capacity are probably under par because all the expertise is not brought together and there is a delay in getting the right kind of support to job seekers with severe mental illness. It is not surprising that their success in gaining work is undermined.¹⁵

Inquiry participants' concerns regarding the duration of the assessment process and the accuracy of assessments in identifying mental health related support needs were shared by many witnesses in the Federal Inquiry.¹⁶ To address these concerns, the Federal Inquiry recommended that:

The Commonwealth Government work with employment service providers to streamline assessment processes for jobseekers with a mental illness and ensure that the assessment criteria for and requirements of job seekers with a mental illness are compatible and consistent across the services.¹⁷

The Committee supports this recommendation. In addition, the Committee considers that there is a need to bridge the structural divide between specialist mental health and employment services that is contributing to delays in the provision of employment support.

The Committee considers there is a stronger role for the Victorian Government to play in bridging the gaps between the employment support and mental health systems. As outlined in Chapter 8, the Committee determined that local partnerships between mental health and employment support services could be fostered through existing Community Mental Health Planning and Service Coordination Initiatives to increase collaboration across sectors. The Committee also identified benefits in establishing joint service delivery models involving the location of employment specialists within mental health services (see Recommendation 8.5).

14 *Submission 15*, Prahran Mission UnitingCare, pp.4-5.

15 *Transcript of evidence 17*, Psychosocial Research Centre, 28 February 2012, p.4.

16 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, pp.178-83.

17 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.180.

6.2.2 Enabling a staged return to work

Several Inquiry participants commented on the importance of allowing job seekers with mental illness to take a staged approach when returning to work. The Committee heard that employment services need to provide more opportunities for jobseekers with mental illness to undertake a small number of hours each week before gradually increasing their working hours.

To be eligible for employment support through DES, jobseekers with mental illness must be assessed as having the capacity to work at least eight hours per week. However, in its submission to the Federal Inquiry, the MI Fellowship identified that ‘eight hours is just too big a step for many people [with mental illness] to make.’¹⁸

The Committee heard that people with mental illness can often benefit from a step-up approach when returning to work. For example, Eastern Access Community Health (EACH), a community health service and employment service provider in eastern Melbourne, explained that it begins by placing people with mental illness into what it calls ‘recovery jobs’. EACH’s General Manager of Employment and Social Enterprise, Mr Wayne Allen, explained to the Committee that:

We work collaboratively with mental health programs to support job seekers’ needs. Some clients commence with what we call a recovery job. That is a job that they go into first, which is an easy job—probably only a few hours a week—to try to get them back into the workforce. We try to work with them, and from there we move them through into a full-time job or to the hours that are needed to meet the benchmark with DEEWR [the Department of Education, Employment and Workplace Relations].¹⁹

During the Inquiry, the Committee visited several social firms across Melbourne. These social firms also facilitated a gradual re-entry into employment for people with mental illness. Employees began by working a few hours a day a couple of days a week. This enabled them to become used to the work environment and the routine of work before increasing their working hours to around 15 hours per week by the end of the first month. Employees who had difficulties maintaining an increase in their working hours were able to reduce their hours to a more manageable level.

The Committee met with a number of employees during the site visits. These employees told the Committee that this step-up approach was essential in enabling them to re-enter employment. In many cases, they had not worked for several years and felt that they would not have had the stamina or confidence to take on more than a few hours’ work initially. With a step-up approach that allowed them to build up their confidence before taking on additional hours, a number were now working several eight-hour days each week.

18 Mental Illness Fellowship of Victoria (2011) *Response to the inquiry into mental health and workforce participation*, submission to the House of Representatives Standing Committee on Education and Employment, Parliament of Australia, Inquiry into mental health and workforce participation, p.4.

19 *Transcript of evidence 12*, EACH Employment, 24 February 2012, p.2.

6.2.3 The importance of post-placement support

The Committee heard that people with mental illness can often require some level of ongoing support throughout their employment to manage the impact of their symptoms on their work performance. This support may need to be available on a flexible basis to account for the episodic nature of mental illness. That is, there may be times when people can sustain work roles without any additional support. However, at other times, more intensive workplace support may be needed to help people manage exacerbations in their symptoms. This may include providing greater flexibility in working hours or making adjustments to work tasks to help employees manage stress or difficulties in concentrating.²⁰

The importance of supporting people with mental illness in the workplace to sustain their work roles is considered in greater detail in Chapter 7. As Chapter 7 discusses, the Committee considered that responding early in workplaces to keep people in work needs to be a critical part of the policy response to addressing the low rate of workforce participation among people with mental illness.

The Committee heard, however, that one of the consequences of the allocation of jobseekers with mental illness into inadequate funding streams is that employment services may not provide sufficient post-placement support to enable people to sustain work roles. For example, candidates who experience a decline in their symptoms following job placement may benefit from assistance in disclosing their mental illness and in negotiating workplace adjustments.

Although employment services can often be successful in placing people into jobs, the Committee heard that ‘the trick is sustaining the job, and unless there’s a support regime in place to get people over the hurdles, then those jobs fall apart.’²¹ As the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) told the Committee:

There is a need for employment support services to help people with mental illness sustain employment and address the varying needs that arise due to the changing nature of disabilities, workplaces and different phases in a job ... People with mental illness using employment services are often assigned the lowest level of disability employment assistance. This leaves them without adequate support during job search or during work placement.²²

20 Perkins, R., Farmer, P., & Litchfield, P. (2009) *Realising ambitions: Better employment support for people with a mental health condition—A review to government*. London, Disability and Work Division, United Kingdom Government Department for Work and Pensions p.28.

21 *Transcript of evidence 6*, Psychiatric Disability Services Victoria (VICSERV) & Eastern Regions Mental Health Association (ERMHA), p.10.

22 *Submission 41*, Victorian Equal Opportunity and Human Rights Commission, p.9.

Box 6.1 The value of post-placement support

Eastern Access Community Health (EACH) Employment is an employment service provider in eastern Melbourne that has been assisting people with mental illness to find jobs for more than twenty years.

To help sustain employment for people with mental illness, EACH self-funds Employer Liaison Officers who liaise with businesses employing job seekers with mental illness.

The role of the Employer Liaison Officer is to educate employers on how to manage and support employees with mental illness as well as to address any concerns that employers might have about clients placed in their business.

EACH illustrated the benefits of this approach by discussing its experience in recently placing a jobseeker with mental illness in a large multinational company.

The jobseeker had not disclosed his mental illness to his employer. After the jobseeker began exhibiting unusual behaviour, including absenteeism, the company contacted EACH's Employer Liaison Officer to raise their concerns. A case manager then met with the job seeker and his family and persuaded him to disclose his mental illness to his employer.

Once he had disclosed his mental illness, EACH was able to liaise with the company's human resources department to negotiate some adjustments to the work environment that could help address the behavioural issues identified by the employer.

These included arranging for the client's desk to be moved to a quieter location—the work location was an open plan office and the client struggled with noise—and allowing the client to take time out in a designated quiet room if he felt anxious. The Committee heard that with the help of these adjustments, the client was able to maintain his employment instead of being dismissed for work performance issues.

Source: Compiled from *Transcript of evidence 12*, EACH Employment, 24 February 2012, p. 5.

Inquiry participants told the Committee that there is a need for employment programs specific to mental illness. Ms Sarah Cromie, Regional Manager of Employment Services at EACH, advised that:

There are not a lot of mental health-specific programs, and one of the things we have discovered ... is that if you have a tailored program and staff who are trained in providing support for people in employment who have a mental health condition, the outcomes are greater and the ownership that the individual takes of their employment pathway is greater as well.²³

FINDING 4

That jobseekers with mental illness may benefit from tailored employment programs that:

- Allow for a gradual increase in working hours.
- Provide more intensive support following job-placement to assist in managing disclosure of mental illness and negotiating workplace adjustments to cope with declines in symptoms.

²³ *Transcript of evidence 12*, EACH Employment, p.3.

6.3 Supporting employers in providing flexible work options

Participants suggested that policy responses need to address barriers that prevent employers from offering flexible employment opportunities to people with mental illness. As noted in Section 6.1, to sustain employment, people with mental illness often require flexible options.

The Committee heard that providing support to employers to increase their understanding of the benefits of flexible work options and how to manage mental illness in the workplace is critical. In particular, support to employers includes:

- Training and information resources for employers and human resources professionals in:
 - understanding mental illness and the varied experience of mental illness
 - providing flexible work arrangements and other workplace adjustments that can assist with recruiting and retaining workers with mental illness
 - legal obligations (equal opportunity legislation, occupational health and safety legislation) related to disclosure of mental illness in the workplace, confidentiality and employers' duty of care.
- Increasing awareness among employers of support services, subsidies and incentives already available to assist them in recruiting and retaining people with mental illness.

Through its investigations, the Committee identified that the Commonwealth Government has a key role in providing support to employers through wage subsidies and phone information services that employers can access for advice. These types of support are discussed in Section 6.3.2. However, the Committee determined that the VEOHRC also has an important role in promoting education and awareness about providing flexible workplace adjustments to support the employment of people with mental illness.

In providing training and resources for employers and human resources (HR) professionals, the Committee identified that it is also important to consider the different requirements and needs of large organisations and small businesses in relation to accessing information about managing mental health issues within the workplace.

6.3.1 Ways of supporting employers

Ms Christine Couzens, President of the Geelong and Region Trades Hall and Labour Council (GRTHLC), told the Committee that if employers received greater practical assistance, such as an advice service that they can contact in relation to managing employees experiencing mental health issues, more would be willing to recruit people with mental illness:

Having spoken to a lot of different employers, there are some who really do not care but the majority of those employers generally feel that if they had the support and guidance to assist their workers, they would do that, but there is nothing there. When they ring the local mental health services, they just say 'We cannot help you with it'. There is nowhere to go to pick up on that.²⁴

²⁴ *Transcript of evidence 3*, Geelong and Region Trades Hall and Labour Council, 4 November 2011, p.7.

Ms Kerry Donaldson, Manager of the Bendigo Youth Support and Advocacy Service (YSAS) stated that employers often ‘have good intentions but unless you provide them with appropriate training and support, they just become tired, fatigued and overwhelmed.’²⁵

Evidence received by the Federal Inquiry similarly indicated that ‘small businesses were willing to take on people with mental ill health but wanted to know that there was assistance available if they needed it.’²⁶

Ms Karen Milne, a group member of the peer-support organisation, GROW, suggested that employers could benefit from a phone support service that they could contact for advice on managing mental health issues within the workplace:

Perhaps some sort of phone support service would be good ... If an employer can identify that there is a problem, they could get some advice on how to approach that person, because it is really a tricky area a lot of the time. If the employees could access that service as well, that might just prevent lots of people ending up out of the workforce in those times prior to absolute crisis.²⁷

Other Inquiry participants suggested a need to develop and promote published resources to employers. The Australian Human Resources Institute (AHRI), in its submission, recommended ‘establish[ing] an employer information kit where all the available support (including wage subsidies etc.) is clearly outlined.’²⁸

The PRC suggested that the Victorian Government:

Fund the development of multi-media and website resources to strengthen community members’ access to information about resources, reasonable adjustments and supports that assist re-entry and participation in education, training, and employment. This should be developed with people who have direct experience of re-entry and participating in education, training, and employment, as well as consultation with other stakeholder groups for whom the information is being developed (e.g. employers, teachers, families), to ensure its relevance and usefulness.²⁹

FINDING 5

That providing training and information services to employers in the management of mental health issues in the workplace can assist employers to successfully recruit and retain people with mental illness.

6.3.2 Increasing awareness of available supports

Through its investigations, the Committee identified that several information services are already available to employers that can provide guidance and advice in relation to recruiting and retaining people with mental illness. However, it identified that awareness of these supports and information services is generally low.

25 *Transcript of evidence 7*, Youth Support and Advocacy Service (YSAS), 18 November 2011, p.9.

26 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.109.

27 *Transcript of evidence 2*, GROW, 4 November 2011, p.6.

28 *Submission 24*, Australian Human Resources Institute (AHRI), p.10.

29 *Submission 37*, Psychosocial Research Centre, p.3.

Support services in Victoria

At a state level, an important responsibility of the VEOHRC is to support Victorian employers to meet their obligations under the *Equal Opportunity Act 2010* (Vic) (EO Act). The Commission's website indicates that it provides a range of services that include:

- expert advice about risk management and equal opportunity best practice
- education and training programs.³⁰

The VEOHRC provides education and training on equal opportunity to employers in several ways. It regularly delivers training workshops to help employers understand 'best practice' strategies to promote equal opportunity in the workplace. This includes workshops on providing reasonable adjustments and flexible work arrangements for employees with disability or mental illness. These workshops are complemented by a telephone enquiry line and professional consultancy service that employers can contact for information and advice related to their obligations under the EO Act.³¹

The Committee considered that the VEOHRC's telephone enquiry line and broader education programs provide an avenue for delivering guidance and support to employers in relation to managing workers with mental illness. For example, some of the VEOHRC's current workshops include a specific focus on workers with mental illness. These include workshops on:

- managing return-to-work after physical or mental illness or injury
- working with employees with mental illness—a workshop targeted at human resources professionals, managers and supervisors.³²

The Committee identified, however, that the VEOHRC's website for employers, *Right Smart Employers*, and information about its enquiry line do not mention how the VEOHRC can assist employers in managing workers with mental illness. Consequently, employers may not be fully aware of the advice that the VEOHRC can provide in relation to making reasonable adjustments and providing flexible work arrangements to facilitate the employment of people with mental illness.

The Committee considered that the VEOHRC could work with industry groups such as the Victorian Employers' Chamber of Commerce and Industry (VECCI) to raise awareness of its education and training services and how it can assist employers in relation to managing workers with mental illness.

→ RECOMMENDATION 6.2:

That the Victorian Government increase awareness of the Victorian Equal Opportunity and Human Rights Commission (VEOHRC) support services for employers and the assistance that the VEOHRC can provide to employers in making reasonable adjustments for workers with mental illness.

30 Victorian Equal Opportunity and Human Rights Commission (2012) *Customised training programs*. Accessed on 5 September 2012 from http://www.humanrightscommission.vic.gov.au/index.php?option=com_k2&view=item&layout=item&id=979&Itemid=491.

31 Victorian Equal Opportunity and Human Rights Commission (2012) *Human rights and equal opportunity training calendar July—December 2012*. Accessed on 5 September 2012 from http://www.humanrightscommission.vic.gov.au/index.php?option=com_k2&view=item&layout=item&id=1267&Itemid=814.

32 Victorian Equal Opportunity and Human Rights Commission (2012) *Human rights and equal opportunity training calendar July—December 2012*.

Available supports for employers at a national level

The Committee identified that additional support and information services, including wage subsidies and a telephone advisory service, are provided at a national level for employers. However, the Committee found that there is limited awareness of these services and supports among employers. It determined that Government needs to work with employer groups, professional associations, and unions to increase awareness of these supports and services among employers.

The Commonwealth Government funds and administers a range of financial incentives and information services designed to assist and encourage employers to recruit and retain jobseekers with disability or mental illness. These include wage subsidies as well as funding to offset the costs of any workplace adjustments that may be needed to facilitate the employment of people with mental illness.

Information about these financial supports and incentives is available through JobAccess, a free information and advice service funded by the Commonwealth Government to assist employees and employers.³³ JobAccess offers advice about:

- how to create a supportive and healthy work environment
- how to search for a job and keep that job
- step-by-step guides on recruitment, adjusting a workplace and understanding rights and responsibilities at work
- work related modifications and services for people with disability or mental illness
- DES and programs.³⁴

The JobAccess website also includes published resources for employers on recruiting, managing and supporting employees with mental illness. This includes a guide developed by the Australian Human Rights Commission (AHRC), *Workers with mental illness: A practical guide for managers*.

The AHRC guide is endorsed by Safe Work Australia, the Fair Work Ombudsman, *beyondblue*, the Mental Health Council of Australia (MHCA), and SANE.³⁵ It offers comprehensive advice to managers and employers regarding:

- developing mental health strategies within businesses
- creating a safe and health workforce through identifying possible workplace practices, actions or incidents which may cause, or contribute to, the mental illness of workers
- offering flexible working arrangements and mentoring and peer support systems
- providing access to counselling services and/or specialist support groups
- developing greater understanding through education and training.³⁶

33 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.109.

34 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.109.

35 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.117.

36 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, pp.117-18.

Table 6.1 provides an overview of a number of key incentives funded by the Commonwealth Government to assist employers in recruiting workers with mental illness.

Table 6.1: Wage subsidies and funding for workplace adjustments

Support/incentive	Overview
Employment Assistance Fund	<ul style="list-style-type: none"> Provides financial assistance to purchase a range of work-related modifications and services for people with disability or mental illness who are about to start a job or who are currently working. Employers, employment service providers, and individual workers can apply for funding to meet the cost of work-related modifications. To be eligible for assistance, the worker must have an ongoing disability that <ul style="list-style-type: none"> has lasted, or is likely to last, for at least two years and which results in a limitation, restriction or impairment that substantially affects the person's employment and everyday activities.
Supported Wage System	<ul style="list-style-type: none"> The supported wage system provides an incentive for employers to take on people whose productivity is affected by mental illness. Through the supported wage system, employers can pay productivity-based wages in lieu of full award wages to workers whose work productivity is reduced due to the effects of their mental illness.
Occasional wage subsidies for people with mental illness	<ul style="list-style-type: none"> From 1 July 2012, employers who recruit clients of Disability Employment Services (DES) for at least 15 hours a week for 26 weeks are eligible for a one-off wage subsidy payment of \$3,000. Employers who employ people through the supported wage system are eligible for a one off payment of \$2,000, payable after they have employed a person for a minimum of 15 hours a week, for 26 weeks.³⁷
Jobs in Jeopardy (Jij)	<ul style="list-style-type: none"> Jij assistance is for employees at risk of losing their employment as a result of injury, disability, or a health condition (including mental illness). Jij is provided through DES and can be accessed by either employers or individual job seekers for up to six months. Participants receive face to face support as well as advice about job redesign and workplace modifications assistance.

Source: Compiled by Family and Community Development Committee.

Participants in this Inquiry expressed mixed views about the effectiveness of wage subsidies and other financial incentives in motivating employers to recruit jobseekers with mental illness:

- Mission Australia and JobWatch supported the use of wage subsidies and funding for workplace modifications.³⁸

³⁷ Department of Education, Employment and Workplace Relations, Department of Health and Ageing, & Department of Families, Housing, Community Services and Indigenous Affairs (2011) *Response to the inquiry into mental health and workforce participation*, joint submission to the House Standing Committee on Education and Employment, Parliament of Australia, Inquiry into mental health and workforce participation, p.12.

³⁸ *Submission 29*, Mission Australia, p.13; *Submission 44*, JobWatch, p.26.

- AHRI and the Recruitment and Consulting Services Association (RCSA) questioned whether wage subsidies could motivate employers to offer employment to people with mental illness on a sustained basis.³⁹

The Committee also questioned whether the effectiveness of subsidies in fostering employment could be increased through reducing the number of hours that people with mental illness are required to work in order for businesses to be eligible for subsidies. As discussed in Section 6.2.2, people with mental illness may benefit from a staged return to work. Fifteen hours of work each week may be too much initially for some people with mental illness.

The Committee considered that an evaluation should be undertaken to determine whether reducing the number of hours' employment that businesses are required to provide could increase the effectiveness of wage subsidies.

→ RECOMMENDATION 6.3:

That the Victorian Government encourages the Commonwealth Government to undertake a review of the effectiveness of wage subsidies in fostering employment of people with mental illness, including:

- An assessment of whether reducing the 15 hour requirement would enhance the effectiveness of subsidies to employers of people with mental illness.

Employer awareness of available supports

Inquiry participants told the Committee that employers can often be unaware of the information services, wage subsidies and other financial supports that exist to help businesses employ people with mental illness.

Mr Serge Sardo, Chief Executive Officer of AHRI, told the Committee that 'in most cases employers do not even know they [the subsidies] exist.'⁴⁰ SANE similarly stated in its submission that:

Employers and employees are often unaware of the support available from government and non-government services ... More active promotion of JobAccess and related programs is needed by Government, so that many more employees affected by mental illness—and their employers—can benefit from the services they provide.⁴¹

These concerns reflect the findings of research commissioned by DEEWR into employer attitudes towards employing people with mental illness. This research found that 'CEOs [Chief Executive Officers] and HR Managers, overall, had extremely low awareness, if any, of the range of government support available for employees with mental health conditions.'⁴²

39 *Transcript of evidence 9*, Australian Human Resources Institute (AHRI), 21 November 2011, p.6; *Submission 22*, Recruitment and Consulting Services Association (RCSA), p.10.

40 *Transcript of evidence 9*, Australian Human Resources Institute (AHRI), p.6.

41 *Submission 7*, SANE, p.6. See also SANE (2011) *Research bulletin 14: Working life and mental illness*. Melbourne, SANE, p.2.

42 Department of Education, Employment and Workplace Relations (2008) *Employer attitudes towards employing people with mental illness*. Canberra, Department of Education, Employment and Workplace Relations, Commonwealth of Australia, p.27.

This issue was also identified in the Federal Inquiry, which found that ‘there is a limited knowledge about the JobAccess, Employment Assistance Fund and Jobs in Jeopardy Program alike.’⁴³

In relation to the JobAccess information services in particular, the Standing Committee identified that even experts working in the field of mental illness and employment are unaware of the service. It stated that it did not discover the number for contacting the JobAccess service ‘until some way through the Inquiry and there was little evidence or knowledge of it among employers.’⁴⁴ The Standing Committee concluded that:

If there is to be a greater uptake of all these initiatives [JobAccess service, Employment Assistance Fund, and Jobs in Jeopardy Program], there needs to be a clearer and more actively promoted communication strategy about what services are on offer, how they can assist employees and employers alike, and the process to follow for accessing the available support services.⁴⁵

The Committee shares this view. It identified that a targeted campaign is needed to increase awareness among employers of the supports that are available to help with employing people with mental illness. This could be achieved through Government working closely with industry groups at a state level to promote the availability of existing support services for employers. As outlined in Section 6.3.3, the Committee identified that working in partnership with industry groups is important in up-skilling employers and managers in how to recruit and retain employees with mental illness.

FINDING 6

That existing information services and incentives to support employers in recruiting and providing flexible work arrangements for people with mental illness need to be more widely advertised.

→ RECOMMENDATION 6.4:

That the Victorian Government works together with the Commonwealth Government to increase awareness of information services and supports available for workplaces that employ people with mental illness.

6.3.3 Mental health literacy for employers

Many Inquiry participants suggested that workplace mental health education and training programs are needed to provide practical guidance to employers on how to manage mental health issues in the workplace. Participants identified targeted training programs for recruiters, line managers and supervisors as critical because of their ‘pivotal role in managing and supporting an employees’ return to work after an episode of mental illness.’⁴⁶

43 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, pp.115-16.

44 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.110.

45 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, pp.115-16.

46 *Submission 16*, Open Minds, p.6.

Identifying appropriate workplace adjustments

The Committee heard that managers and supervisors find the varied and fluctuating experience of mental illness a challenge to understand and accommodate. AHRI stated in its submission that:

In general, most [employers] are not equipped to understand how a mental illness can impact the workplace and, even more importantly, how to manage someone with a mental illness. The result is often under-management and neglect that can lead to under-performance and isolation of the employee until a predictable self-fulfilling prophecy related to ability becomes a reality.⁴⁷

JobWatch highlighted that the effects of mental illness are not always visible to employers. Ms Zana Bytheway, Executive Director of JobWatch, explained that this makes it more difficult to determine the sort of workplace adjustments that might be needed for an employee with mental illness:

It is not always clear what types of adjustments actually need to be made for people with psychological disabilities as opposed to those more obvious adjustments that need to be made for people with physical disabilities. For example, for people with physical disabilities you can enlarge a computer screen or you can lower or raise benches for chair use et cetera. So I think people have a greater understanding of how to accommodate physical disabilities, but we do not believe it is as obvious or clear what to do for those with psychological disabilities.⁴⁸

This issue was also identified by AHRI in its submission:

Post-employment employer support for people with mental illness is generally far more complex and critical than for people with physical disabilities. In most cases the employment modification needs of people with physical disabilities can be accommodated via ergonomic modifications. For cases of employees with mental illness simple physical adjustments are not appropriate and managers are often left to make many assumptions on the job about a person who requires specialist or customised assistance and are left to themselves about how best to try to manage an employees with a mental illness.⁴⁹

Managing disclosure of mental illness

The Committee identified that in many cases appropriate workplace adjustments could be determined through discussion between employers and employees experiencing mental health issues. The Committee heard however that employers can be reluctant to raise mental health issues with employees because of concerns about breaching equal opportunity and anti-discrimination legislation.

Associate Professor Anthony LaMontagne from the VicHealth Centre for the Promotion of Mental Health and Community Wellbeing (McCaughey Centre) told the Committee that:

Many employers are rightly concerned that if they say the wrong thing to someone they think might have a mental illness, they could end up in court. That might be in the very best interests of the worker, but if they do not know how to talk about it and where the boundaries are, that is a real problem for them ...⁵⁰

47 *Submission 24*, Australian Human Resources Institute (AHRI), p.8.

48 *Transcript of evidence 26*, JobWatch, 21 March 2012, p.6.

49 *Submission 24*, Australian Human Resources Institute (AHRI), p.7.

50 *Transcript of evidence 24*, Associate Professor Anthony LaMontagne—VicHealth Centre for the Promotion of Mental Health and Community Wellbeing (McCaughey Centre), 7 March 2012, p.7.

AHRI told the Committee that employers ‘are really anxious about the ramifications of breaching such acts—OH&S [occupational health and safety] acts, the discrimination act, unfair dismissal and those sorts of things.’⁵¹ Social Firms Australia (SoFA) similarly stated in its submission that:

Employers, employees and employment support services feel poorly equipped to manage a disclosure of mental illness in the workplace. Employers need to know if there are mental health issues affecting an employee’s ability to work but are uncertain how to respond if they have concerns and are fearful of breaching the disability discrimination act.⁵²

FINDING 7

That employers and supervisors may benefit from professional development on workplace adjustments for employees with mental illness and managing the disclosure of mental health issues in the workplace.

Workplace mental health awareness training

The Committee considers that a training strategy to up-skill employers, managers and supervisors in working with employees with mental illness and providing suitable workplace adjustments is needed. Research commissioned by DEEWR in 2008 indicates that training is needed in:

- awareness of mental illness and the varied experience of mental illness
- vocational impairments associated with different mental illness and information on how best to support and manage an employee who is experiencing difficulties due to their mental illness
- legal obligations about disclosure, confidentiality and duty of care
- how to plan and prepare for an employee with mental illness starting work, including supports available to the employee
- how organisational policies can be flexible and responsive to an employee who becomes unwell, requires a reduction in work hours and then, when better, wishes to increase hours or return to work
- training in effective communication as well as how best to respond in a crisis situation.⁵³

Inquiry participants identified a pressing need for mental health literacy training programs within workplaces, with specific training programs, for managers, HR staff and general staff. The Victorian Mental Health Carers Network (VMHCN) told the Committee that:

Development of mental health literacy in the workplace is a critical response to this question—understanding the actions and behaviours required to support those with mental illness, remembering that many choose not to disclose their condition. Employers need to be as informed about mental health risks just as they are on other

51 *Transcript of evidence 9*, Australian Human Resources Institute (AHRI), p.2.

52 *Submission 43*, Social Firms Australia, pp.4-5.

53 Department of Education, Employment and Workplace Relations (2008) *Use of the workplace modifications scheme to assist the employment of people with mental illness*. Canberra, Department of Education, Employment and Workplace Relations, Commonwealth of Australia, p.14.

OH&S risks; businesses need to have an in-depth understanding of mental health information; they need insight as well as strategic and systemic processes in place to support people with illness, thus ultimately minimising costs. Participation in this area [should] be mandatory for all those who direct, manage and supervise others, not only in discrete parts of businesses such as OH&S, HR etc.⁵⁴

In its submission, SANE highlighted that:

An important but often-neglected aspect of successful employment of people with a mental illness is understanding by others in the workplace. This means more than broad sympathy; it means providing managers and co-workers with the knowledge and skills to supervise, work alongside, and—when necessary—to support a colleague with a mental illness, or who is a carer of someone affected by mental illness.⁵⁵

During the course of the Inquiry, the Committee became aware of several existing programs to build mental health literacy within workplaces in addition to the workshops offered by the VEOHRC. These programs include tailored resources and workshops for HR staff, management personnel, and general staff on a range of topics related to mental illness and employment, including:

- understanding various mental illnesses and their impacts on employment
- early intervention and prevention strategies, including strategies to build employee resilience and encourage help-seeking
- the legal and occupational health and safety obligations of employers and employees in relation to managing disclosure of mental illness
- designing workplace adjustments to support employees with mental illness
- assisting employees to return to work following mental health-related sickness absences.

Appendix 4 provides an overview of workplace mental health literacy training programs delivered by Mental Health@Work, *beyondblue*, and SANE.

Despite the availability of these programs, research shows that relatively few workplaces are adequately equipped to deal with mental health issues in the workplace. For example, a 2010 survey of 26,000 members of the Australian business community by Beaton Consulting and *beyondblue* found that 83 per cent had not received any training to deal with mental health issues in the workplace.⁵⁶

To facilitate the wider reach of workplace mental health literacy training, the Committee considered that mental health literacy training could be incorporated within human resources and management training curricula. It determined that establishing mental health literacy training as an ongoing component of training curricula would achieve a more sustained approach to developing the capacity of business to manage mental health issues within the workplace.

The Committee also identified scope for the Victorian Government to engage industry groups (and in partnership with training providers) to promote the up-take of workplace mental health literacy training programs to businesses.

⁵⁴ *Submission 26*, Victorian Mental Health Carers Network, p.4.

⁵⁵ *Submission 7*, SANE, p.2.

⁵⁶ Reported in *Submission 16*, Open Minds, p.6.

Industry groups are well placed to broker contacts with businesses' HR and OH&S personnel to promote wider reach of workplace mental health programs. The Committee noted the example of the existing partnership between AHRI and SANE in promoting SANE's workplace mental health literacy program (see Appendix 4) to HR professionals.⁵⁷ A mental health training workshop for HR managers delivered in partnership with *beyondblue* is also offered by AHRI to members as part of its broader range of training and professional development programs.

→ RECOMMENDATION 6.5:

That the Victorian Government, in partnership with relevant stakeholders, develops a training strategy to up-skill employers and supervisors in working with employees with mental illness and how to provide suitable workplace adjustments, including:

- Incorporating mental health literacy training within human resources and management training curricula.
- Engaging industry groups to promote the up-take of workplace mental health literacy training programs among members.

6.3.4 Supporting small business

The Committee identified that large organisations and small businesses have varying capacities to participate in, and benefit from, workplace mental health literacy training programs. Alternative forms of support in how to manage mental health issues within the workplace, such as a telephone information and advice service, may be more suited to the needs of small business.

Small business accounts for almost half of all private sector employment in Victoria.⁵⁸ The Department of Business and Innovation (DBI) highlighted to the Committee that:

The majority of [small businesses] are time and resource poor. It is fair to say that there has been limited capacity among small business operators to develop a well-articulated employment policy that encompasses all areas including mental illness ...⁵⁹

The Committee heard that small businesses have limited capacity to participate in mental health literacy training programs delivered within workplaces. Mr Simon Schweigert, Project Manager with RCSA, told the Committee that most small businesses do not have dedicated HR personnel. Consequently, if workplace mental health literacy training is targeted at HR personnel, this 'will miss a large proportion of the workforce.'⁶⁰

57 *Transcript of evidence to the House of Representatives Standing Committee on Education and Employment*, Parliament of Australia, Inquiry into mental health and workforce participation, Ms Barbara Hocking (Executive Director, SANE), Melbourne, 13 April 2011, p.23.

58 Small Business Victoria (2011) *Small Business Victoria discussion paper*. Melbourne, Department of Business and Innovation, State of Victoria, p.4.

59 Letter from Mr Justin Hanney, Deputy Secretary, Trade and Industry Development, Department of Business and Innovation, to Chair, Victorian Parliament Family and Community Development Committee, 26 June 2012, p.2.

60 *Transcript of evidence 20*, Recruitment and Consulting Services Association (RCSA), 7 March 2012, pp.7-8.

Research commissioned by DEEWR in 2008 into employer initiatives to support the recruitment of people with mental illness has similarly found that ‘small businesses in particular may have limited time and capacity to participate in educational programs, or to access information about mental illness.’⁶¹ This research suggested that small businesses could benefit from the promotion of a single point of access for information and advice about mental health issues in the workplace.⁶²

Inquiry participants shared this view. Ms Cromie from EACH told the Committee that:

Out in the eastern metropolitan area we deal with a lot of small to medium employers, and they have very limited knowledge of HR practices ... Knowing that they can ring someone and talk through the difficulties they are having with their employees would make a huge difference, even if it is a support line for small to medium businesses that links into employment service providers to provide that assistance.⁶³

As noted earlier, a phone support service is already provided through the Commonwealth’s JobAccess service while the VEOHRC also operates an enquiry line for employers. Published guidelines for employers on managing workers with mental illness are also available through the JobAccess website. These guidelines outline reasonable workplace adjustments for people with mental illness and the obligations of employers and employees in relation to disclosure of mental illness, occupational health and safety requirements and equal opportunity legislation. However, there is limited awareness of the JobAccess website and information service among employers.

The Committee identified that while businesses of all sizes could benefit from greater promotion of the JobAccess service, it is particularly important to communicate the availability of JobAccess and related services to small businesses.

→ **RECOMMENDATION 6.6:**

That the Victorian Government works with the Commonwealth to target small business as part of a campaign to increase employer awareness of information resources and supports available for workplaces that employ people with mental illness (see Recommendation 6.4).

61 Department of Education, Employment and Workplace Relations (2008) *Employer initiatives—Supporting the recruitment and retention of people with mental illness*. Canberra, Department of Education, Employment and Workplace Relations, Commonwealth of Australia, p.viii.

62 Department of Education, Employment and Workplace Relations (2008) *Employer initiatives—Supporting the recruitment and retention of people with mental illness*, p.viii.

63 *Transcript of evidence 12*, EACH Employment, p.7.

6.4 Supported employment options for people with mental illness

People with mental illness may have varying employment needs related to differences in their experience of mental illness. The Committee identified that some people with mental illness may benefit from having greater flexibility and more intensive workplace support than is often available within mainstream businesses.

Most people with mental illness want to work in open, mainstream employment and consider it a key element in their recovery.⁶⁴ Inquiry participants indicated however that ‘not everyone is ready for work in the mainstream labour market.’⁶⁵ In its submission, VincentCare highlighted that:

There will be people who have experienced mental illness for a long time and, so too, their journey back into mainstream society and workforce participation will possibly need to adopt a longer-term strategy. Some people will also experience more severely disabling or intransigent mental health problems.

For these groups of people, the *open* employment market neither may not viably support their productive employment, nor be the optimum first step into paid work. Yet, people may still be able to work, achieve productivity and experience the social inclusion and well-being benefits of paid employment in *specialised* employment environments.⁶⁶

The Committee heard that social firms and social enterprises (see Box 6.2) can provide valuable employment options and pathways for people with severe mental illness who, for various reasons, may not be ready for open employment. This can include:

- people with high ongoing support needs that are difficult to accommodate within mainstream workplaces
- people who require highly flexible work arrangements to attend regular treatment sessions or manage the effects of medication
- people who find it difficult to obtain employment in the open labour market due to limited work experience or work skills.

64 Bond, G.R. (2004) ‘Supported employment: Evidence for an evidence-based approach’. *Psychiatric Rehabilitation Journal*, Vol. 27, No. 4, pp.345-59, pp.345-6.

65 *Transcript of evidence 22*, Social Ventures Australia, 7 March 2012, p.6.

66 *Submission 28*, VincentCare Victoria, p.8.

Box 6.2 Glossary of supported employment options

Social enterprises can be defined as business ventures that:

- are led by an economic, social, cultural, or environmental mission consistent with a public or community benefit
- trade to fulfil their mission
- derive a substantial portion of their income from trade
- reinvest the majority of their profit/surplus in the fulfilment of their mission.⁶⁷

Social firms are a type of social enterprise that has the employment of people with disability or mental illness as its goal.⁶⁸ Social firms have a supportive work environment that:

- employs between 25 and 50 per cent of employees with disability or mental illness
- pays all workers at award/productivity-based rates
- provides the same work opportunities, rights and obligations to all employees
- generates the majority of its income through the commercial activity of the business
- any modifications required for the employee in need of support are built into the design of the workplace.⁶⁹

Australian Disability Enterprises (ADEs) are commercial business ventures that are partly funded by the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) to provide meaningful work opportunities to people with disability or mental illness 'whose employment opportunities would be very limited or non-existent if they were to compete for a job in the open labour market.'⁷⁰

Employees in ADEs may consist exclusively of people with disability or mental illness and ADE employees can often be paid productivity-based wages rather than award wages. For example, in 2010, the average gross hourly wage paid to ADE employees was \$3.61 compared to an Australian national minimum wage of \$15.51 per hour.⁷¹

Nearly all supported employees working in ADEs (96 per cent) are Disability Support Pension (DSP) recipients.⁷² Only around 12 per cent of ADE employees list mental illness as their main disability (a further four per cent list mental illness as a secondary disability).⁷³

Source: Compiled by Family and Community Development Committee.

67 Barraket, J., Collyer, N., O'Connor, M. et al. (2010) *Finding Australia's social enterprise sector: Final report*. Social Traders and the Australian Centre for Philanthropy and Nonprofit Studies, Queensland University of Technology, p.16.

68 *Submission 43*, Social Firms Australia, p.1.

69 Social Firms Australia. (2012) *Social firms*. Accessed on 17 August 2012 from <http://socialfirms.org.au/social-firms>.

70 Department of Families, Housing, Community Services and Indigenous Affairs (2010) *Inclusion for people with disability through sustainable supported employment: Discussion paper*. Canberra, Department of Families, Housing, Community Services and Indigenous Affairs, Commonwealth of Australia, p.10.

71 Advisory group on inclusion of people with disability through sustainable supported employment (2012) *Advisory group: vision for sustainable supported employment*. Canberra, Department of Families, Housing, Community Services and Indigenous Affairs, Commonwealth of Australia, pp.23-24.

72 Department of Families, Housing, Community Services and Indigenous Affairs (2010) *Inclusion for people with disability through sustainable supported employment: Discussion paper*, p.11.

73 Department of Education, Department of Health and Ageing, & Department of Families, Housing, Community Services and Indigenous Affairs (2011) *Response to the inquiry into mental health and workforce participation*, p.27.

6.4.1 Social firms

Social firms are one type of social enterprise that trade specifically to provide employment to people with disability or mental illness. In its submission, SoFA highlighted two key features of social firms:

- the majority of income is generated through the business activity
- there is an integrated mix of employees with and without mental illness or disability.⁷⁴

Ms Caroline Crosse, Executive Director of SoFA, told the Committee that having a mix of employees with and without mental illness is important for two reasons:

I realise, now, that that is actually important from the business perspective—if you have got at least 50 per cent of your staff that you can reasonably rely on to turn up at 8 in the morning or to take on more pressured jobs, the business is more likely to be sustainable. Also the social inclusion aspect means that it is a much more dignified, productive way of working if you help to enable the broader population to take responsibility for the support needs of people with a mental illness through the role modelling and the setting of standards of productivity.⁷⁵

Support strategies and workplace adjustments are also built into the design of social firms to assist people with mental illness to maintain their employment.⁷⁶ As outlined in Section 6.2.3, this can include providing a step-up approach for workers with mental illness returning to employment after several years outside the workforce or a period of extensive treatment.

The Committee identified that social firms in Victoria operate according to different models in terms of the employment pathways they provide for people with mental illness:

- Employment destinations—some social firms provide long-term employment in a supportive work environment to people with mental illness. These social firms can often be funded as Australian Disability Enterprises (ADEs), though not always.
- Intermediary labour market organisations—others provide short-term transitional employment to equip people with the skills, experience, and confidence they need to compete for employment in the open labour market.

Intermediary labour market organisations (ILMOs)

In Victoria, several social firms and social enterprises have been established as ILMOs. These businesses provide employment in a supportive work environment on a transitional rather than long-term basis. The focus is on helping people to develop the confidence and work skills they need to gain competitive employment positions in the mainstream labour market.

Trainees in ILMOs typically receive on-the-job training and work towards gaining accredited qualifications in skills that are in demand in the broader labour market. Organisations that operate ILMOs are often also registered training organisations for this purpose. When people near the end of their traineeship, assistance is provided to find employment in the open labour market.⁷⁷

74 Submission 43, Social Firms Australia, p.1.

75 Transcript of evidence 15, Social Firms Australia, 28 February 2012, p.2.

76 Submission 43, Social Firms Australia, p.2.

77 Mestan, K. & Scutella, R. (2008) *Investing in people: Intermediate labour markets as pathways to employment*. Melbourne, Brotherhood of St Laurence and Allen Consulting Group, p.1.

Box 6.3 below provides an overview of one example of a social firm that has been established as an ILMO in Victoria, the MadCap café franchise.

Box 6.3 MadCap cafés

The MadCap cafés are cafés operated by two community managed mental health organisations in Victoria, the Eastern Region Mental Health Association (ERMHA) and Pathways Rehabilitation and Support Services.

The first MadCap Café was established a number of years ago in Dandenong by ERMHA after it identified that there were few viable pathways into employment for its clients, many of whom wanted to work. Two more MadCap cafés have since been established in the Westfield shopping centres at Fountaingate and Geelong. Pathways operates the Geelong café on a franchise basis.

Each MadCap café aims to operate as a commercial, self-sustaining business. Excluding the café manager and team leaders, all positions in the cafes are filled on a transitional basis. The cafes also adopt an early intervention approach, reserving around 60 per cent of the trainee positions for people with severe mental illness who are less than 30 years of age.⁷⁸

Before commencing at MadCap, trainees receive pre-vocational training to equip them with work-ready skills, including punctuality and getting out of bed for a reason in the morning. Following pre-vocational training, participants begin to work shifts in the café, where they also receive on-the-job training. All training is self-paced and tailored to the individual. If a trainee needs to take time-off to focus on managing their mental health this is accommodated in the training schedule. Peer support workers with lived experience of the journey of recovery are also paired with trainees to provide mentoring and support throughout the process.

Prior to the completion of training, trainees are linked with a Disability Employment Service or Job Services Australia provider to find employment in the open labour market. The peer support workers continue to provide support to trainees following the completion of their traineeship to ensure a successful transition to competitive employment.

In evidence to the Federal Inquiry, the Chief Executive Officer of ERMHA, Mr Peter Waters, described the outcomes that have been achieved by the MadCap cafés. He told the Standing Committee that over a two-year period of Jobs Fund funding:

- 116 participants had found short-term jobs
- 118 participants had found long-term jobs.⁷⁹

Source: Compiled by Family and Community Development Committee.

Appendix 5 provides an overview of social firms and social enterprises that have been established in Victoria to provide long-term or transitional employment opportunities to people recovering from severe mental illness. These businesses are often concentrated in labour intensive industries such as catering and hospitality and property cleaning and maintenance.

Organisations indicated to the Committee that the motivation for establishing social firms has often been difficulties they have experienced in placing clients into employment via mainstream employment services.

⁷⁸ Submission 23, Pathways Rehabilitation and Support Services & Barwon Health, pp.14-5.

⁷⁹ House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.95.

The Chief Executive Officer of the Eastern Regions Mental Health Association (ERMHA), Mr Peter Waters, told the Committee that ERMHA established the MadCap cafés because:

We essentially banged our heads against brick walls for many years trying to establish pathways for our clients into employment, to the point where we ultimately thought, 'well, if we can't get somebody else to do it for [us] whose job it is to do that, we will do it ourselves.'⁸⁰

6.4.2 Social firms as employment pathways

Inquiry participants expressed broad support for the role of social firms in providing employment options for those who are not yet ready to work in the mainstream labour market. Mr Colin Fryer, Chairman of the VMHCN, told the Committee that:

These businesses [social firms] provide the most suitable environment for some people with very severe illness or long-term employment ... they are most rewarding when they have a structured approach which extends to the consumer being assisted on an optional basis to pursue employment in the open market.⁸¹

The Brotherhood of St Laurence (BSL) likewise stated that:

Social enterprises with an employment focus ... provide a vital opportunity for those who do not meet the levels of functional capabilities or productivity required by mainstream employers. Enterprises that aim to give transitional or permanent paid work must be considered as a key part of an integrated suite of active labour market policy.⁸²

Some Inquiry participants suggested that social enterprises and social firms can be more effective than mainstream employment programs in helping people with severe mental illness to find employment in the open labour market. For example, Mr Paul Bird, Chief Executive Officer of YSAS, told the Committee that 'the record shows that by using social enterprise and transition to work over 70 per cent have sustained full employment through those options.'⁸³ Mr Bird had previously worked for Mission Australia on its social enterprise initiatives.

During the Inquiry, the Committee heard from the BSL which operates several social enterprises in Melbourne based on the ILMO model. The BSL informed the Committee that around 65 per cent of its trainees go on to find employment in the open labour market.⁸⁴ Mr Michael Horn, Senior Manager of Research and Policy, told the Committee:

That is significantly better than the mainstream job services model in terms of job outcomes ... Only one in four [Stream 4, JSA clients] are getting a job outcome and for the majority of those it is casual, seasonal or part-time work, and we know from some of our follow-up longitudinal research at the national level that those jobs do not stick.⁸⁵

Mr Waters from ERMHA informed the Committee that social firms can also play a valuable role in addressing stigma in the community. He explained that the MadCap cafés have a sign on the wall along the lines of:

One in five Australians will experience a mental illness and this café, like any other

80 *Transcript of evidence 6*, Psychiatric Disability Services Victoria (VICSERV) & Eastern Regions Mental Health Association (ERMHA), p.4.

81 *Transcript of evidence 5*, Victorian Mental Health Carers Network, 7 November 2011, p.6.

82 *Transcript of evidence 14*, Brotherhood of St Laurence, 28 February 2012, p.5.

83 *Transcript of evidence 7*, Youth Support and Advocacy Service (YSAS), p.3.

84 *Transcript of evidence 14*, Brotherhood of St Laurence, p.6.

85 *Transcript of evidence 14*, Brotherhood of St Laurence, p.6.

place, is going to have people who work in it with a mental illness, like a toothache or a bad back ... you get on with your job and you get on with your life.⁸⁶

Mr Waters told the Committee that this approach had proven effective in highlighting awareness of mental illness among MadCap customers:

You can see the penny drop for customers ... people say to us, you know, 'We had no idea that's what this was about,' and they talk to us and it's—you know, it's remarkable. So the impact that it has on the stigma in the community is astounding and was not what we had planned.⁸⁷

During site visits, the Committee witnessed first-hand the difference that working in a social firm can make to the recovery of people with mental illness. Employees who met with the Committee spoke of the sense of social inclusion, purpose, and self-esteem they had gained from working in a social firm. Several employees told the Committee that they preferred working in a social form to working in competitive employment. Some had gone on to work in the open labour market but had returned to working in a social firm because of the more flexible working hours. They also valued working alongside other people with mental illness who could understand and relate directly to their experiences of mental illness.

Mr Jeff Galvin, a peer educator with SoFA with experience of working in a social firm, highlighted the role of social firms in assisting the social inclusion of people with mental illness. He told the Committee that:

As somebody living with mental illness, [working in a social firm] is normalising. It makes you feel like you are part of the mainstream. You [don't] want to be in a DE—a disability enterprise. You want to be in a mainstream job that you know is making a profit. You know that it is sustainable and you know that you are an integral part of that sustainability. It feels good.⁸⁸

6.4.3 The viability of social firms

The Committee determined that social firms may fulfil an important role in enabling people with mental illness who have been excluded from employment for several years to experience social inclusion and to build valuable work skills and self-confidence. At the same time, the Committee recognises that social firms are still an emerging sector in Victoria and that greater evaluation of the sector is needed to determine the effectiveness of social firms in providing pathways into sustainable employment in the open labour market.

Mr Kevin Robbie, Executive Director and Team Leader of Social Ventures Australia's (SVA) Employment Division, explained that while social firms and social enterprises have been around since the 1960s in Italy and Germany, 'we are really at the early stages of this [social firm and social enterprise development]' in Australia.⁸⁹ The examples of social firms presented to the Committee were businesses that were often no more than four or five years old.

86 *Transcript of evidence 6*, Psychiatric Disability Services Victoria (VICSERV) & Eastern Regions Mental Health Association (ERMHA), p.8.

87 *Transcript of evidence 6*, Psychiatric Disability Services Victoria (VICSERV) & Eastern Regions Mental Health Association (ERMHA), p.8.

88 *Transcript of evidence 15*, Social Firms Australia, p.7.

89 *Transcript of evidence 22*, Social Ventures Australia, p.6.

The Committee considered that the long-term commercial viability of social firms has yet to be proven. In addition, it determined that there is a need for increased understanding about the types of businesses that can succeed as social firms. For example, Associate Professor Harvey identified that there are only a few social firms in Victoria and that these operate in labour intensive industries such as cleaning, gardening and property maintenance. She told the Committee that:

We do need a diversity of types of work because the types that are available ... are not appropriate for people who maybe have an undergraduate degree or want to do something more clerical or high level in terms of the analytical side of things.⁹⁰

There is also a need for increased understanding of the effectiveness of social firms in transitioning people to long-term sustainable employment in the open labour market. Professor Killackey cautioned that ‘there is not a great deal of evidence that people move from social firms into mainstream employment.’⁹¹

Several Inquiry participants reported positive examples of people going on to find employment in the open labour market after gaining skills and confidence working in a social firm. However, there was acknowledgement that more follow-up evaluations are needed to determine the durability of the jobs obtained by those transitioning into open employment.

Acknowledging that there are still evidence gaps in relation to the sustainability of the job pathways provided by social enterprises, Mr Horn from the BSL explained that organisations have not had the financial resources to carry out follow-up studies, which can be very expensive.⁹²

FINDING 8

That social firms are an emerging sector and there is a need for increased evidence to:

- Determine the sustainability of social firms as commercial businesses.
- Identify whether people with mental illness employed in social firms transition to sustainable jobs in the open labour market.

→ RECOMMENDATION 6.7:

That the Victorian Government undertakes a review of the social firm sector to determine the commercial viability of the sector and the success of social firms in transitioning people with mental illness into sustainable jobs in the open labour market.

6.5 Fostering employment through social procurement

In considering policy responses to facilitate diverse and flexible work options for people with mental illness, the Committee determined that the Victorian Government and local councils can use social procurement to support employment options for people with mental illness. This includes using social procurement to support the creation of employment opportunities in social firms and social enterprises. However,

⁹⁰ *Submission 37*, Psychosocial Research Centre, p.7.

⁹¹ *Transcript of evidence 13*, Orygen Youth Health, p.4.

⁹² *Transcript of evidence 14*, Brotherhood of St Laurence, p.6.

the Committee identified that social procurement policies can also provide incentives for mainstream commercial enterprises to employ people with mental illness.

The Committee recognises that some Victorian Government departments and local councils are already using social procurement to support workforce participation by Victorians with other barriers to employment. The Committee considered that this approach could be expanded upon to include a greater focus on supporting workforce participation by people with mental illness.

6.5.1 The role of social procurement

Social procurement can be defined as ‘the use of purchasing power to create social value.’⁹³ Social Traders explained that social procurement:

Is a strategic approach to generating greater value from procurement through the delivery of social outcomes, above and beyond those provided through the good or service being procured.⁹⁴

Box 6.4 below provides a more detailed explanation of social procurement.

Box 6.4 What is social procurement?

Social procurement involves local councils, government departments and agencies using their purchasing power to achieve social policy objectives, such as the creation of employment for disadvantaged workers, in addition to acquiring goods or services.

There are a number of approaches to social procurement that can be implemented by Government:⁹⁵

- **Promotion**—this approach raises awareness of how purchasing can be engaged to achieve social objectives and may include developing programs to build the capacity of social enterprises and other social benefit suppliers to compete for council contracts. For example, social enterprises can be encouraged to work in consortia or in collaboration with larger suppliers to compete for tenders.
- **Purchasing**—directly purchasing goods and services on either a one-off or ongoing basis from a social enterprise or other social benefit supplier without a formally binding or recurrent contract in place.
- **Procurement**—tailoring tenders and contracts, or creating partnerships and joint agreements, to ensure that social policy objectives are incorporated when purchasing goods and services. For example, tenders and contracts may include clauses specifying that a supplier must employ a certain number of people with mental illness or subcontract out a proportion of the contract to a social firm. Alternatively, the tender or contract may require bidders to outline how they will achieve social impacts if they are awarded the contract.

Source: Compiled by Family and Community Development Committee.

93 Barraket, J. & Weissman, J. (2009) *Social procurement and its implications for social enterprise: A literature review*. Brisbane, The Australian Centre for Philanthropy and Nonprofit Studies, Queensland University of Technology, p.3.

94 *Supplementary evidence 21A*, Social Traders, 7 March 2012, p.1.

95 Department of Planning and Community Development (2010) *Social procurement: A guide for Victorian local government*. Melbourne, Department of Planning and Community Development, State of Victoria, pp.17-18.

Importantly, social procurement is not about exclusively awarding contracts to social enterprises or social firms. This point was highlighted by Social Traders, who advised the Committee that:

Social procurement does not necessarily equate to purchasing from social enterprises. It is about purchasing to maximise social value—which might be delivered by SMEs [small-to-medium sized enterprises], private commercial businesses, indigenous businesses, community sector organisations, as well as from social enterprises.⁹⁶

In the context of social procurement policies that have the employment of people with mental illness as a goal, Mr Mark Daniels, Learning and Development Manager with Social Traders, emphasised that major commercial businesses ‘could employ people with mental health issues quite easily as well.’⁹⁷

Despite this, Inquiry participants indicated that social firms and social enterprises can often be well placed to deliver the social impacts being sought.⁹⁸ In this regard, SoFA suggested to the Committee that ‘social procurement is a very straightforward way to facilitate the development of social firms.’⁹⁹

Mr Bird from YSAS told the Committee that ‘there is an urgent need for this government to have an affirmative policy around social enterprise.’ He went on to suggest that social procurement should be a key part of the policy response to support social enterprise:

There is no reason that local governments and government departments should not purchase from social enterprises. It should not necessarily cost the government any more and they should not compromise on quality, but obviously they are providing valuable training and employment opportunities at the same time.¹⁰⁰

Inquiry participants identified a range of ways social firms and enterprises generate added social value. VincentCare told the Committee that social procurement from a social firm employing people with mental illness reduces Government expenditure on social participation programs and mental health services:

The State Government could ultimately reap good returns in fostering social firms. The returns would come about as a result of people having reduced reliance on other social participation programs, which people may need to use more of, when not engaged in paid employment. The returns would also arise from the reduced use of mental health services. This would result from the longer term recovery which people would experience by having stability, purpose and meaningful social engagement resulting from paid work.¹⁰¹

Mr John Bateup, Chief Executive Officer of WISE Employment, informed the Committee that employees of WISE’s social enterprises completed over 96,000 hours of work in the 2011 financial year.¹⁰² He went on to explain that:

This contributed more than \$290,000 in taxes and earned over \$2.2 million in wages, reducing their dependence on Australian Government benefits and health services whereby helping them to achieve inclusion in all aspects of the community.¹⁰³

96 *Supplementary evidence 21A*, Social Traders, p.2.

97 *Transcript of evidence 21*, Social Traders, 7 March 2012, p.5.

98 Burkett, I. (2010) *Social procurement in Australia*. Sydney, The Centre for Social Impact, University of NSW, p.31.

99 *Transcript of evidence 15*, Social Firms Australia, p.3.

100 *Transcript of evidence 7*, Youth Support and Advocacy Service (YSAS), p.3.

101 *Submission 28*, VincentCare Victoria, p.9.

102 *Transcript of evidence 16*, WISE Employment, Melbourne, 24 February 2012, p.6.

103 *Transcript of evidence 16*, WISE Employment, Melbourne, 24 February 2012, p.6.

Box 6.5 Measuring the social return on investment (SROI) in social firms

The Committee heard that one of the obstacles to social procurement can be ‘understanding the added value created by social procurement.’¹⁰⁴ SROI is one of a number of tools that have been developed to try to measure the social benefits of investing in social firms and social enterprises.

SROI was developed almost 10 years ago in the United States (US) by the Roberts Enterprise Development Fund. The Fund wanted to be able to measure the social value of its investments in enterprises employing people with mental illness, people at risk of homelessness and ex-offenders. SROI has since been developed and applied in the United Kingdom (UK) by the UK Government Cabinet Office. Social Ventures Australia (SVA) introduced the tool to Australia a number of years ago.

SVA has carried out 49 SROI analyses of not-for-profit businesses in Australia. This has included an analysis of the social return on investments in Incito Maintenance, a social firm operated by WISE Employment in Northcote.

Incito Maintenance is a property maintenance business that was established by WISE Employment, with support from Social Firms Australia, in July 2010. As of May 2011, Incito employed 11 people, six of whom were previously excluded from the labour market because of disadvantage, disability, or mental illness.

According to the SROI analysis of Incito Maintenance, every \$1 invested in the social firm generates \$8.24 in added social value:¹⁰⁵

- 52 per cent of this added social value is the outcomes experienced by Incito’s disadvantaged employees whose lives improve significantly as a result of their on-going and secure employment
- 40 per cent of this added social value is realised by Government in the form of welfare savings and an increase in collected tax revenue.

The Committee heard that there can be some limitations with existing SROI analyses. One challenge is determining what constitutes additional social value and arriving at a consistent approach to measuring any social value that is created. Mr Kevin Robbie, Executive Director and Team Leader of SVA’s Employment Division, told the Committee that the ‘lack of access to data for benchmarks and costs in Australia ... makes some of the reporting and analysis quite cumbersome.’¹⁰⁶ He also identified the need ‘to get those who have done it [a SROI analysis of their business] to repeat it—in the same way that if you saw someone with a set of audited accounts that were six years old, you would not really trust them.’¹⁰⁷

Source: Compiled by Family and Community Development Committee.

6.5.2 Examples of social procurement in Victoria

During the Inquiry, the Committee identified several examples of how Victorian Government departments and local councils are already using social procurement to generate employment opportunities for disadvantaged Victorians.

A number of Inquiry participants cited the Public Tenant Employment Program operated by the Housing and Community Building Division in the Department of Human Services (DHS) as an example of best-practice in social procurement.¹⁰⁸

¹⁰⁴ *Transcript of evidence 21*, Social Traders, p.8.

¹⁰⁵ *Transcript of evidence 16*, WISE Employment, 28 February 2012, p.6.

¹⁰⁶ *Transcript of evidence 22*, Social Ventures Australia, p.5.

¹⁰⁷ *Transcript of evidence 22*, Social Ventures Australia, p.5.

¹⁰⁸ *Submission 28*, VincentCare Victoria, p.12; *Transcript of evidence 14*, Brotherhood of St Laurence, p.3.

The Committee noted that the Department of Planning and Community Development (DPCD) has in the past worked with Social Traders to assist local councils to examine how their procurement processes can be applied strategically to address social issues in their municipalities. The work of DPCD and Social Traders in assisting councils to identify opportunities for social procurement has been further supported by the launch the Social Enterprise Finder in May 2012.¹⁰⁹ This is the first comprehensive directory of social enterprises in Australia and provides an accessible tool that councils, government departments and other organisations can use to procure services and products from social enterprises.

Box 6.6 describes the activities of DPCD and other departments in assisting local councils to develop social procurement processes.

Box 6.6 Developing local government expertise and capacity in social procurement

Since 2010, several initiatives have been introduced to develop the capacity of local councils to engage in social procurement. In October 2010, the Department of Planning and Community Development (DPCD) launched *Social procurement: A guide for Victorian local government*. Following the adoption of this guide, Local Government Victoria, the Community Development Division of DPCD, the Department of Human Services and Social Traders partnered to establish an *Expert support program*.

The program was originally designed as a pilot to provide eight local councils with practical assistance in developing their social procurement capacity.¹¹⁰ In response to enthusiasm for the program, a toolkit to provide practical tools for all Victorian councils was developed in 2011.¹¹¹ The toolkit is available from the local government section of DPCD's website. It includes a framework that councils can use in identifying training and employment opportunities for targeted disadvantaged communities that can be generated through procurement.¹¹²

DPCD informed the Committee that the *Expert support program* 'did not involve any direct engagement of social enterprises, including any supporting the training and employment of people with a mental illness.'¹¹³ However, the assistance provided to local councils may have led some councils to purchase goods or services from social enterprises, although DPCD could not confirm that this was the case.¹¹⁴

Source: Compiled by Family and Community Development Committee.

Table 6.2 lists several practical examples of social procurement initiatives that have been implemented by Victorian Government departments and local councils to

¹⁰⁹ Letter from Mr Andrew Tongue, Secretary of the Department of Planning and Community Development, to Chair, Victorian Parliament Family and Community Development Committee, 28 June 2012, p.2.

¹¹⁰ The eight local councils were: Benalla Rural City Council, Brimbank City Council, Darebin City Council, Glenelg Shire Council, Hume City Council, Maribyrnong City Council, Moonee Valley City Council and Wittlesea City Council.

¹¹¹ Department of Planning and Community Development (2011) *Procurement for social and economic development outcomes in local communities: Mapping and analysis methodology*. Melbourne, Department of Planning and Community Development, State of Victoria, p.3.

¹¹² Department of Planning and Community Development (2011) *Procurement for social and economic development outcomes in local communities: Mapping and analysis methodology*, p.3.

¹¹³ Letter from Mr Andrew Tongue, Secretary of the Department of Planning and Community Development, to Chair, Victorian Parliament Family and Community Development Committee, 28 June 2012, p.1.

¹¹⁴ Letter from Mr Andrew Tongue, Secretary of the Department of Planning and Community Development, to Chair, Victorian Parliament Family and Community Development Committee, 28 June 2012, p.1.

generate employment and training opportunities. The Committee also recognises that several large private sector businesses are supporting the employment of people with mental illness through awarding major cleaning and maintenance contracts to social firms. For example, WISE Employment informed the Committee that major contracts from Telstra and the Dallas Brooks Centre help its Clean Force Property Services social firm to generate annual revenue of around \$2 million.¹¹⁵ This illustrates that social procurement can be of interest to private sector organisations as well as Government.

Table 6.2: Examples of social procurement by Victorian Government departments and local councils

Initiative	Agency	Targeted outcomes	Details
Public Tenant Employment Program	Housing and Community Building Division, Department of Human Services (DHS) (formerly Office of Housing)	Employment of public housing tenants	<p>Since 2005, a public tenant employment clause has been inserted into all public housing maintenance contracts and the majority of construction contracts.</p> <p>Where the value of a contract exceeds \$300,000, one previously unemployed public housing tenant must be employed on a full-time basis for the duration of the contract.</p> <p>An additional public housing tenant must be employed for each further \$300,000 increase in contract value.¹¹⁶</p> <p>More than 650 jobs and 1,300 training opportunities for previously unemployed public housing tenants have been created since 2005.¹¹⁷</p>
Public housing estate concierge services	Housing and Community Building Division, DHS	Employment of public housing tenants	<p>When putting out a tender for concierge services on the Fitzroy, Richmond, and Collingwood Public Housing Estates in 2009, DHS' Housing and Community Building Division stipulated that the successful bidder must:</p> <ul style="list-style-type: none"> • employ 90 per cent of employees from the public housing communities being serviced • support tenant employees to transition into the open labour market at the conclusion of a 12-month contract • train tenant employees in a Certificate III Traineeship in Community Services.¹¹⁸ • Despite competition from a commercial bidder, the contract was awarded to the Community Contact Service (CCS), a social enterprise established in 2005 by the Brotherhood of St Laurence (BSL) as part of the Victorian Government's Community Enterprise Development Project.¹¹⁹

115 *Transcript of evidence 16*, WISE Employment, p.38.

116 Department of Planning and Community Development, (2010) *Social procurement: A guide for Victorian local government*, p.52.

117 Burkett (2010) *Social procurement in Australia*, p.19.

118 Social Traders (2009) *Case Study—Intermediate labour market company: Community Contact Service*. Melbourne, Social Traders, pp.3-4.

119 Social Traders (2009) *Case Study—Intermediate labour market company: Community Contact Service*.

Initiative	Agency	Targeted outcomes	Details
Council street cleaning contract	Yarra City Council	Employment of public housing tenants	<p>In 2006, Yarra City Council partnered with the BSL to employ previously unemployed public housing tenants through a BSL social enterprise to provide street cleaning services in North Fitzroy and North Carlton.</p> <p>The social enterprise operated as an intermediary labour market organisation.</p> <p>Yarra City Council subsequently recruited a number of the trainees into the council depot workforce in areas such as graffiti removal and weed control.¹²⁰</p>
Municipal bike paths construction project	Banyule City Council	Employment and training of people with low skills aged 16 to 25 years	<p>Banyule City Council partnered with Mission Australia to secure \$400,000 of Commonwealth funding for a social enterprise to construct two bike paths in the municipality.</p> <p>People with low skills aged 16–25 years from the identified suburbs of West Heidelberg and Watsonia and participants from a group training scheme were employed by the Mission Australia social enterprise to construct the bike paths.</p> <p>On and off the job training in Certificate II and III Horticultural (Landscaping) was provided to program participants in conjunction with a local training organisation.¹²¹</p>
Waste transfer station management	Darebin City Council Knox City Council Mornington Peninsula Shire Council	Employment of Victorians with barriers to workforce participation, including mental illness	<p>Darebin City Council has contracted Outlook Environmental to operate the municipality's waste transfer station and resource recovery centre in Reservoir.¹²²</p> <p>Outlook Environmental is a social enterprise that provides jobs and vocational training to around 70 workers, many of whom have mental illness.</p> <p>Darebin City Council awarded the contract to manage the Reservoir waste transfer station to Outlook Environmental after a competitive tender process.</p> <p>Knox City Council and Mornington Peninsula Shire Council have also awarded contracts to manage waste transfer stations to Outlook Environmental.</p>

Source: Compiled by Family and Community Development Committee.

120 Department of Planning and Community Development, (2010) *Social procurement: A guide for Victorian local government*, p.21.

121 Department of Planning and Community Development, (2010) *Social procurement: A guide for Victorian local government*, p.35.

122 Department of Planning and Community Development, (2010) *Social procurement: A guide for Victorian local government*, p.42.

The Committee considered that there is benefit in undertaking an evaluation of existing social procurement initiatives to determine their effectiveness in creating long-term employment outcomes among Victorians previously excluded from employment. The evaluation should also consider the social and economic benefits resulting from these employment outcomes. This evaluation could assist in promoting the benefits of social procurement to other government departments and local councils.

→ **RECOMMENDATION 6.8:**

That the Victorian Government undertakes an evaluation to determine the long-term employment outcomes achieved by social procurement initiatives and the resulting social and economic benefits.

6.5.3 Future directions for social procurement in Victoria

The Committee considered that Victorian Government departments, agencies and local councils could build upon existing social procurement initiatives to support the workforce participation of people with mental illness by:

- Finding more opportunities to purchase goods and services from suppliers employing people with mental illness:
 - Government departments and agencies and local councils should be encouraged to find opportunities to award work to, or purchase goods and services from, businesses employing people with mental illness.
 - Procurement spend targets for purchasing from businesses employing disadvantaged Victorians, including people with mental illness, could be mandated to ensure the implementation of social procurement practices.¹²³
 - Alternatively, government departments and agencies and local councils could be required to report each year on how their procurement spending has created added social value or provided employment opportunities to Victorians with mental illness.

VincentCare suggested that the Victorian Government and local councils could incorporate tender criteria within contracts that ‘give preference to businesses that employ people with a diagnosed mental illness.’¹²⁴ The Committee identified however that social firms and social enterprises can experience challenges in competing for government contracts and tenders because of:

- low awareness of social firms and social enterprises among purchasers
- the structure of government contracts and tenders.

¹²³ See Burkett (2010) *Social procurement in Australia*, p.25.

¹²⁴ *Submission 28*, VincentCare Victoria, p.12.

Box 6.7 discusses how Brisbane City Council has sought to address these challenges through unbundling government contracts and including a list of social enterprises within the Council's supplier database.

Box 6.7 Brisbane City Council's social procurement policy

Over the past 10 years, Brisbane City Council has sought to use its procurement practices to generate added social value. In doing so, however, the Council identified that many newer and smaller social enterprises lack the capacity to compete for commercial contracts.

The Council recognised that these newer and smaller enterprises are important to the diversity of the Council's supplier base into the future. It has therefore implemented several initiatives to develop the capacity of these enterprises to become Council suppliers.

One initiative has been the unbundling of contracts to create opportunities for small social enterprises to supply goods and services to the Council. For example, previously the contract to maintain all the parks under the Council's jurisdiction was put out to tender as a single contract. This advantaged larger contractors. The Council decided to unbundle the maintenance of smaller parks from this contract to allow smaller social enterprises to provide some park maintenance services.

The Council also sought to grow the capacity of social enterprises to compete for Council contracts through educating social enterprises about how to win business under the Council's procurement rules and through engaging mentors to work with and support social enterprises. In 2006, the Council partnered with Social Ventures Australia (SVA) and PricewaterhouseCoopers to establish the Brisbane Social Enterprise Hub. The Hub provides procurement support and business development support, as well as access to mentoring and pro bono support from a range of corporate partners to around 10 social enterprises.

A Social Procurement Policy and Plan was also developed within Council to communicate the rationale for, and public benefits of, social procurement. An internal list of social enterprise suppliers that can be accessed through the Council's supplier database was also developed.

Source: Adapted from Burkett, I. (2010) *Social procurement in Australia*. Sydney, The Centre for Social Impact, University of New South Wales, p. 25.

→ RECOMMENDATION 6.9:

That the Victorian Government proactively supports social procurement through businesses employing workers with mental illness by:

- Educating government departments and local councils about the social value of procuring goods and services from businesses that employ people with mental illness.
- Increasing awareness of social firms and enterprises that can supply goods and services—for example through promotion of the Social Enterprise Finder to government departments and local councils.
- Working with government departments and local councils to identify opportunities to procure goods and services from businesses employing people with mental illness.

Chapter Seven: Fostering healthy and supportive workplaces

Findings

1. That intervening early to support people with mental illness to continue in their existing job is essential to improving workforce participation.
2. That mental injury claims account for an increasing share of all occupational injury claims within the Victorian WorkCover scheme (close to 11 per cent of all claims).
3. That mental injuries are associated with lengthy absences and early exits from work.
4. That mental injury claims are more complex to investigate and assess than physical injury claims, which may lead to delays in workers receiving support to return-to-work.
5. That Employee Assistance Programs (EAP) are independent of the workers compensation system but can assist in early identification of mental health issues and in providing guidance to employees and managers on workplace adjustments and strategies that can assist in maintaining employment.
6. That to ensure consistent delivery of EAP interventions, industry standards are needed.
7. That peer support programs are valuable in assisting people with mental illness to participate in employment.
8. That support from employers is a key factor in the successful employment of people with mental illness.
9. That employees returning to work after an episode of mental illness benefit from return-to-work plans specific to mental illness.

The importance of early intervention and prevention was an underlying theme in the evidence provided to the Committee. As discussed in Chapter 4, the impact that the onset of mental illness in youth has on people's engagement in education is a critical influence on workforce participation by people with mental illness.

This chapter considers the importance of intervening early in workplaces to prevent people from falling out of employment due to mental illness. This relates to supporting people to sustain their employment during times when they are unwell. It also includes addressing factors within the workplace that can exacerbate, or contribute to, mental illness such as bullying and job stress.

The Committee determined that workplace strategies to assist employees experiencing mental illness to maintain their employment and to reduce work-risks to mental health need to be a critical part of the policy response to promoting workforce participation by people with mental illness. This is integral to achieving sustained change.

Several initiatives that workplaces can implement to support employees to stay well and remain at work were identified by the Committee. These include Employee Assistance Programs (EAPs), peer support networks, and return-to-work plans that are specific to mental health. In addition, the Committee determined that it is important workplaces foster employee wellbeing at an organisational level through addressing aspects of workplace cultures, working conditions and management practices that can undermine employees' mental health.

The Committee recognises the key role of employers and co-workers in fostering healthy and supportive working environments. It also considered that the Victorian Government, through WorkSafe, has an important role in providing leadership and knowledge in creating healthy and supportive workplaces.

7.1 Responding to mental illness in workplaces

Inquiry participants told the Committee that achieving sustained change requires more than creating pathways into employment for people with mental illness. Equally important is recognising that there are many people with mental illness who are already in the workforce, as well as many who will develop mental illness during their employment.

Ensuring that people in the workforce are supported to maintain their employment during episodes of mental illness is critical to their long-term recovery and the broader participation of people with mental illness in the labour market. In this regard, Dr Dina Bowman, Principal Researcher at the Brotherhood of St Laurence, told the Committee that:

What is important is that it is not just having an ambulance at the bottom, it is having a fence at the top of the cliff. Many of the people I interviewed as part of [a study on integrated employment support for people with mental illness] were middle class, doing well, well educated and in work. Then they developed a mental health condition for whatever reason, and because they were not provided with adequate support at the right time, that led to job loss, which has then led to or was associated with relationship breakdown and homelessness.¹

Similarly, Ms Leonie Nowland, Clinical Services Director at Davidson Trahaire Corpsych, told the Committee that while there are a number of funded programs to help get into jobs:

It has always seemed to me to be a bit of a no-brainer that if a small amount of money was spent to support people who are currently employed in their role, you would have a much better chance of success rather than waiting for people to fall off the perch and then trying to get them into jobs.²

FINDING 1

That intervening early to support people with mental illness to continue in their existing jobs is essential to improving workforce participation.

At the same time, the Committee heard that it is also important to foster healthy and safe workplaces that reduce the risk of people developing mental illness and experiencing disruptions to their workforce participation. For example, the Chair of the former Victorian Mental Health Reform Council (VMHRC), Mr Terry Laidler, told the Committee that reducing work-risks to mental health is important in 'mak[ing] sure that people already in the workplace ... don't develop bigger problems.'³

The Victorian Mental Health Carers Network (VMHCN) cautioned that it needs to be remembered that:

Work environments have their own psychological risk factors that can contribute to the development of a mental illness or exasperate existing and perhaps dormant mental illness as well as hinder a healthy return-to-work process.⁴

1 *Transcript of evidence 14*, Brotherhood of St Laurence, 28 February 2012, p.7.

2 *Transcript of evidence 18*, Davidson Trahaire Corpsych, 7 March 2012, p.2.

3 *Transcript of evidence 4*, Victorian Mental Health Reform Council, 7 November 2011, p.4.

4 *Submission 26*, Victorian Mental Health Carers Network, p.3.

This is illustrated by a 2011 study of data on job quality, unemployment and mental health from the Household, Income and Labour Dynamics in Australia (HILDA) surveys carried out by researchers at the Australian National University.⁵ The researchers found that people who were employed generally had better mental health than those who were unemployed. But those who moved from unemployment into jobs with little job security or control over work tasks experienced a decline in mental health.⁶

The Executive Director of JobWatch, Ms Zana Bytheway, told the Committee that its employment legal rights centre receives approximately 1,100 calls each year from employees 'who are suffering or may go on to suffer a significant mental health issue.'⁷ Between 25 and 30 per cent of these calls are from people who develop mental health issues during their employment.

Ms Bytheway explained that:

Although it is often presumed that mental health issues are developed outside the workplace, it needs to be remembered that a workplace incident or unhealthy work environment can contribute to or exacerbate the development of mental illness.⁸

She gave the example of workplace bullying, stating that it 'is an incredibly traumatic experience which often impacts and creates huge anxiety and stress and often depression occurring in the workplace context.'⁹

Associate Professor Anthony LaMontagne from the VicHealth Centre for the Promotion of Mental Health and Community Wellbeing (McCaughey Centre) told the Committee that job-strain is another key factor within workplaces that can contribute to the development of mental illness.¹⁰

Job-strain occurs when people face high demands in their job but have little control over how they can do their job. Associate Professor LaMontagne told the Committee that it approximately doubles a person's risk of developing depression. Indeed, he estimated that job-strain is responsible for about 13 per cent of all depression in working men and approximately 17 per cent of all depression in working women in Victoria.¹¹

A consistent message from Inquiry participants was that the role of the work environment in promoting/hindering people's mental health needs to be clearly recognised by business and employers. This is essential to reducing the prevalence of mental illness in the community and increasing levels of productivity within workplaces. Mission Australia stated in its submission:

Identifying and implementing early intervention strategies to reduce the financial burden of reduced or lost productivity is required. It is also vital that businesses are

5 Butterworth, P., Leach, L.S., Strazdins, L. et al. (2011) 'The psychosocial quality of work determines whether employment has benefits for mental health: Results from a longitudinal national household panel survey'. *Occupational and Environmental Medicine*, No. 10.1136/oem.2010.059030.

6 Butterworth, Leach, Strazdins et al. (2011) 'The psychosocial quality of work determines whether employment has benefits for mental health: Results from a longitudinal national household panel survey'.

7 *Transcript of evidence 26*, JobWatch, 21 March 2012, p.3.

8 *Transcript of evidence 26*, JobWatch, pp.3-4.

9 *Transcript of evidence 26*, JobWatch, p.4.

10 *Transcript of evidence 24*, Associate Professor Anthony LaMontagne—VicHealth Centre for the Promotion of Mental Health and Community Wellbeing (McCaughey Centre), 7 March 2012, p.3.

11 *Transcript of evidence 24*, Associate Professor Anthony LaMontagne—VicHealth Centre for the Promotion of Mental Health and Community Wellbeing (McCaughey Centre), p.3.

aware of the need to operate a workplace that has inclusive recruitment, retention and workplace practices for both existing workers and for their future employees to help stem their financial losses. These practices need to recognise the impact that an unhealthy work environment can have on an individual including exacerbating existing, or contributing to the development of mental illness ...¹²

7.1.1 The benefits for individuals and employers

The Committee identified that fostering healthy and supportive workplaces that reduce the risk of employees becoming unwell and that support staff who develop mental illness to maintain their employment has several benefits for businesses and individuals.

The VMHCN highlighted that, given support at the right time, ‘people well into tertiary education or into good careers [who] are hit by mental illness ... may well recover and continue with a successful life.’¹³ SANE suggested that ‘better understanding and support for employees affected by mental illness not only helps them stay in work, it also contributes to more effective management of staff and resources for the employer.’¹⁴ This includes reductions in work absences related to mental illness.

In evidence to the Committee, Dr Nicola Reavley from the Centre for Youth Mental Health cited data from the Work Outcomes Research Cost-Benefit Project in relation to mental health and sickness absence among Australian workers.¹⁵ This study involved 58 organisations and approximately 60,000 employees. It showed that in any given month, 4.5 per cent of full-time employees have high levels of psychological distress. Dr Reavley told the Committee that high levels of psychological distress increase sickness absences among workers by about 18 per cent, resulting in ‘an annualised loss of 8.8 weeks a year.’¹⁶

Inquiry participants also identified substantial costs related to mental health risks within workplaces. For example, in its submission, JobWatch identified several costs related to workplace bullying and its impact on the wellbeing and productivity of employees. These include ‘decreased productivity and efficiency, increased staff absenteeism, staff turnover and poor morale.’¹⁷ Additional financial costs can also include ‘legal and workers’ compensation and management time in addressing cases of workplace bullying.’¹⁸ Overall, the Productivity Commission estimates that the cost of workplace bullying to the Australian economy may be as high as \$36 billion each year.¹⁹

As noted in Chapter 2, the Committee heard that mental health problems caused by work stress and other work-related psychosocial hazards such as bullying and

12 *Submission 29*, Mission Australia, p.13.

13 *Transcript of evidence 5*, Victorian Mental Health Carers Network, 7 November 2011, p.4.

14 *Submission 7*, SANE, p.5. See also SANE (2011) *Research bulletin 14: Working life and mental illness*. Melbourne, SANE, p.1.

15 *Transcript of evidence 28*, Centre for Youth Mental Health, University of Melbourne, 21 March 2012, p.2.

16 *Transcript of evidence 28*, Centre for Youth Mental Health, p.3.

17 *Submission 44*, JobWatch, p.17.

18 *Submission 44*, JobWatch, p.17.

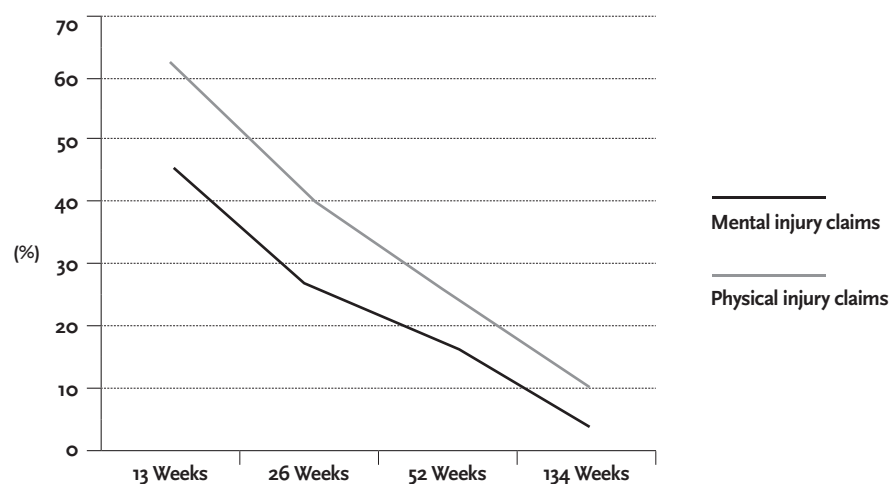
19 Reported in House of Representatives Standing Committee on Education and Employment, Parliament of the Commonwealth of Australia, *Education and employment committee to launch inquiry into workplace bullying*, Media release, 1 June 2012.

harassment are becoming an increasingly significant source of occupational injury and ill health.²⁰

In the 2010–11 financial year, more than 3,000 mental injury claims were lodged within the Victorian WorkCover scheme.²¹ Mr Greg Tweedly, former Chief Executive Officer of WorkSafe, informed the Committee that mental injury claims now account for around 11 per cent of all occupational injury claims in Victoria and have been increasing as a proportion of all injury claims in recent years. He explained that this is of concern as ‘it is very much harder to assist [people who make mental stress claims] in returning to work.’²²

As Figure 7.1 shows, close to a quarter of workers in Victoria who make a mental injury claim lasting one month or more are still off work after a year. Close to 10 per cent are still off work after more than two years.

Figure 7.1: Continuance rates for WorkCover claims lasting one month or more, 2010–11



Source: *Supplementary evidence 27A*, WorkSafe Victoria, p.13.

For this reason, mental injury claims are significantly more costly on average (\$69,000 per claim) than physical injury claims (\$58,000 per claim).²³ WorkSafe advised the Committee that mental injury claims are also more complex to assess and investigate.²⁴ This can increase the length of time that it takes for mental injury claims to be processed, as discussed in Box 7.1. As a result, workers may experience delays in receiving assistance to return to work. Employers are not required to support an employees' return to work until a claim has been accepted.

20 *Submission 41*, Victorian Equal Opportunity and Human Rights Commission, p.5.

21 *Transcript of evidence 27*, WorkSafe Victoria, 21 March 2012, p.5.

22 *Transcript of evidence 27*, WorkSafe Victoria, p.5.

23 *Transcript of evidence 27*, WorkSafe Victoria, p.5.

24 Letter from Mr Ian Forsyth, Acting Chief Executive, WorkSafe Victoria, to Chair, Victorian Parliament Family and Community Development Committee, 19 September 2012, p.3.

Box 7.1 The assessment of mental injury claims

Under the *Accident Compensation Act 1985* (Vic), WorkSafe agents must make a decision to accept or reject an injury claim within 28 days of receipt.²⁵ In many cases, the assessment of occupational injury claims can be completed within a shorter time frame. For example, approximately 48 per cent of physical injury claims are either accepted or rejected within seven days of receipt. This compares with 15 per cent of mental injury claims.²⁶

Significantly, almost 80 per cent of mental injury claims take at least 19 days to process once they have been received by WorkSafe.

WorkSafe advised the Committee that ‘as the circumstances that may give rise to a mental injury claim may not be attributable to a single event, the diagnosis of mental injury can be more complex than obvious physical injuries, particularly where there are pre-existing conditions.’²⁷ Mr Tweedly, former Chief Executive Officer of WorkSafe, explained that ‘it is a very complex set of circumstances as to what extent cause and effect [of mental health problems] can be identified at work’ and ‘there is not a strong base for the standards on mental injury.’²⁸

Source: Compiled by Family and Community Development Committee.

The Committee was informed that people who experience work-related mental health problems also wait longer before lodging an injury claim. WorkSafe advised that the average duration between an injury occurring and the receipt of a claim is 35 days in the case of mental injury claims, compared with 27 days for all claims. This appears to be because workers who experience work-related mental health problems wait longer before lodging a claim with their employer, who then forwards the claim to WorkSafe.²⁹ This may lead to delays in people being referred for medical treatment, or to services such as EAPs that may assist with early interventions to help people remain at, or quickly return to, work.

The Committee considered that fear of stigma may be a contributing factor to the delay in people raising mental injuries with their employer. It identified that fostering healthy and supportive workplace cultures in which people feel confident to disclose mental illness may enable people to seek help earlier. This issue is considered further in Section 7.4.

The difficulties that people experience in returning to work mean that people who take time off from work because of mental injury are at risk of experiencing long-term unemployment. For example, Ms Claire Amies, Head of the Transport Accident Commission’s (TAC) Health Services Group, told the Committee that if a person is off work for more than six months this significantly reduces their chances of ever

25 Letter from Mr Ian Forsyth, Acting Chief Executive, WorkSafe Victoria, to Chair, Victorian Parliament Family and Community Development Committee, 19 September 2012, p.2.

26 Letter from Mr Ian Forsyth, Acting Chief Executive, WorkSafe Victoria, to Chair, Victorian Parliament Family and Community Development Committee, 19 September 2012, p.3.

27 Letter from Mr Ian Forsyth, Acting Chief Executive, WorkSafe Victoria, to Chair, Victorian Parliament Family and Community Development Committee, 19 September 2012, p.3.

28 *Transcript of evidence 27*, WorkSafe Victoria, p.5.

29 WorkSafe advised the Committee that there is little difference between the length of time that it takes for employers to forward mental injury claims to the WorkCover authority for investigation compared with physical injury claims. Letter from Mr Ian Forsyth, Acting Chief Executive, WorkSafe Victoria, to Chair, Victorian Parliament Family and Community Development Committee, 19 September 2012, p.3.

returning to work.³⁰ Reinforcing this, the Sainsbury Centre for Mental Health stated in preparing a report on work and wellbeing:

If an individual is off work for 12 months, they are unlikely to return to work for another seven years. If they have been off work for two years, the chances of returning to work decline even further, so that they are more likely to retire rather than ever return to work.³¹

FINDING 2

That mental injury claims account for an increasing share of all occupational injury claims within the Victorian WorkCover scheme (close to 11 per cent of all claims) and are associated with lengthy absences and early exits from work.

FINDING 3

That mental injuries are associated with lengthy absences and early exits from work.

FINDING 4

That mental injury claims are more complex to investigate and assess than physical injury claims, which may lead to delays in workers receiving support to return to work.

7.2 Primary prevention within the workplace

In view of the impact that work-related mental health issues have on people's participation in employment, the Committee identified that it is critical to foster resilient and supportive workplaces that promote mental health. To this end, Inquiry participants suggested that promoting positive workplace cultures and healthy work practices is critical to reducing exposure to risk of mental injury in the workplace. This involves intervening at an organisational level to address aspects of workplace cultures, working conditions, and management practices that can either promote or hinder employees' mental health.³²

A joint report by the World Health Organisation (WHO) and International Labour Organisation (ILO) identifies several characteristics of work environments that are hazardous to mental health. Table 7.1 lists these characteristics.

30 *Transcript of evidence 23*, Transport Accident Commission (TAC), 7 March 2012, p.4.

31 Sainsbury Centre for Mental Health (2007) *Briefing 34: Work and wellbeing—Developing primary mental health care services*. London, Sainsbury Centre for Mental Health, p.2.

32 Noblet, A. & LaMontagne, A. (2006) 'The role of workplace health promotion in addressing job stress'. *Health Promotion International*, Vol. 21, No. 4, pp.346-53, p.350.

Table 7.1: Work characteristics harmful to mental health in the workplace

Work characteristics	Examples
Organisational function and culture	<ul style="list-style-type: none"> • Poor task environment and lack of definition of objective. • Poor problem solving environment. • Poor communication. • Non-supportive culture.
Role in organisation	<ul style="list-style-type: none"> • Role ambiguity. • Role conflict. • High responsibility for people.
Career development	<ul style="list-style-type: none"> • Carer uncertainty. • Carer stagnation. • Poor status. • Poor pay. • Job insecurity and redundancy. • Low social value to work.
Decision latitude/control	<ul style="list-style-type: none"> • Low participation in decision-making. • Lack of control over work. • Little decision-making in work.
Interpersonal relationships at work	<ul style="list-style-type: none"> • Social or physical isolation. • Poor relationships with supervisors. • Interpersonal conflict and violence.

Source: Adapted from Harnois, G. and Gabriel, P. (2000) *Mental health and work: Impact, issues and good practices*, report for the World Health Organisation and International Labour Organisation, p.10.

It was suggested to the Committee that increasing social support by supervisors and co-workers is also one of the simplest ways of promoting mental health in workplaces.³³

In this regard, Dr Reavley told the Committee that:

In order to really get that primary prevention [of work-risks to mental health] happening there needs to be a systems approach—you know, developing psychologically healthy workplaces—where senior management buys in. Because ultimately, if these things are going to cost money, there needs to be that involvement. It is very hard to get that workplace culture that is supportive. A lot of things, even around more the return to work and disclosure and the help, are not going to happen unless that workplace culture is really supportive of that.³⁴

In its submission, Open Minds also identified the contribution that supportive workplace cultures can make to employees' mental health:

The workplace plays a crucial role in promoting positive mental health outcomes and maintaining mental well being. A supportive and inclusive workplace values people with mental illness and treats them equitably without fear of discrimination

³³ *Transcript of evidence 24*, Associate Professor Anthony LaMontagne—VicHealth Centre for the Promotion of Mental Health and Community Wellbeing (McCaughy Centre), p.7.

³⁴ *Transcript of evidence 28*, Centre for Youth Mental Health, p.3.

and stigma. This requires an organisational culture that takes a systemic approach to mental health in the workplace and creates an environment of trust and respect between managers, employees and colleagues.³⁵

7.2.1 Challenges in implementing primary prevention programs

The Committee identified that the prevention of work-risks to mental health is a regulatory requirement under Victorian occupational health and safety legislation. Section 21 of the *Occupational Health and Safety Act 2004* (Vic) (OHS Act) requires employers to ‘so far as is reasonably practicable, provide and maintain for employees ... a working environment that is safe and without risks to health.’ Section 5 of the OHS Act is explicit in stating that ‘health’ includes psychological health.³⁶

Victoria also has strong laws against workplace bullying. This is legislated against in both the OHS Act and, in more serious cases, the *Crimes Act 1958* (Vic).

Occupational health and safety laws governing risks to workers’ psychological health are enforced by WorkSafe Victoria. However, the onus is on employers to implement policies and practices to minimise work risks to health.³⁷ Mr Tweedly from WorkSafe told the Committee that one of the challenges in promoting compliance around the elimination of work-risks to mental health is ‘that there is little agreement ... across industry on the standards of risks to psychological health and psychological hazards.’³⁸

The Committee heard that employers may also be reluctant to acknowledge, or even be unaware, that working conditions influence the mental health of employees. For example, Dr Reavley expressed the view that employers often only respond to mental health issues in the workplace after an issue has arisen:

They tend to get interested [in mental health issues] once there is a problem and someone has gone off and is coming back to work. It is less easy to get them interested in the more primary prevention, perhaps, when they see that they may or may not ever have a problem. It is very much harder to do that, as with most prevention things.³⁹

A number of participants with experience in delivering workshops on mental health prevention and promotion in the workplace told the Committee that employers also have concerns about employees making mental stress claims.

The organisation Mental Health @ Work delivers comprehensive mental health programs in workplaces that address:

- issues around managing employees with mental illness
- assisting early return-to-work of those who go on mental-related sick leave
- organisational level policies to promote mentally healthy work environments and supportive work cultures.

Mr Bernard McNair, Director of Mental Health @ Work, told the Committee that they struggle to get into some workplaces because ‘there is a common thought that

³⁵ Submission 16, Open Minds, p.2.

³⁶ *Occupational Health and Safety Act 2004* (Vic) s 5.

³⁷ *Transcript of evidence 27*, WorkSafe Victoria, p.3.

³⁸ *Transcript of evidence 27*, WorkSafe Victoria, p.4.

³⁹ *Transcript of evidence 28*, Centre for Youth Mental Health, p.3.

if you have programs like ours ... it is immediately going to put up the number of stress-related claims.⁴⁰

In a recent research project, Associate Professor LaMontagne found that employers were keen for staff to participate in *beyondblue's* mental health literacy training. In collaboration with *beyondblue*, the project identified that employers were less receptive to employees taking part in workshops that implied the workplace may be a contributing factor to mental illness:

At one site where we did a participatory workshop at which people raised concerns but also solutions we were promptly kicked out because the person in charge said, 'No, we do not have job stress problems here. Thank you very much; you can go now.' This is the harsh reality of it. You need leadership and sanctioning from the top to try to improve things and take a long-term view towards productivity, sustainability of the business and sustainability at work, which many employers do not feel is their responsibility.⁴¹

Associate Professor LaMontagne suggested that combining education about how to create a mentally-healthy work environment with mental health literacy training may be the most effective way of engaging employers about mental health risk reduction in the workplace:

Employers are lining up all over for mental health literacy. They are not lining up for job stress intervention, so it is a nice idea to put the two together, and I think it is really what we should be doing in the future. It is much more palatable for employers and is less threatening ... employers have to be gotten over that hurdle of making the effort to improve working conditions for the long term. In the short term it is possible that they might get a job stress claim, so there is a disincentive there. It is a very tough nexus. Mental health literacy on the other hand they are asking for all over the place, which is fantastic, so putting the two together might be a way to do a better job of preventing mental illness in the workplace.⁴²

The Committee identified there would be benefits in increasing awareness among employers of the value of mentally healthy workplaces, as well as practical strategies that can be implemented within workplaces to foster employee wellbeing. Increasing employer awareness of mental health issues through workplace mental health literacy training programs, discussed in Chapter 6, can assist in creating positive workplace cultures. Several workplace mental health literacy training programs (see Appendix 4) include components on building resilient and positive workplace cultures.

The Committee recognises that WorkSafe has also developed resources on controlling and preventing workplace bullying and job stress. For example, the latest edition of WorkSafe's guidebook on *Preventing and Responding to Bullying in the Workplace* was published in June 2009 in conjunction with WorkCover New South Wales (NSW). WorkSafe has also developed tailored guidance for employees, health and safety representatives, and employers in the private sector, as well as separate guidelines for public sector workers, on preventing and managing work-related stress.

40 *Transcript of evidence 19*, Mental Health @ Work, 7 March 2012, p.5.

41 *Transcript of evidence 24*, Associate Professor Anthony LaMontagne—VicHealth Centre for the Promotion of Mental Health and Community Wellbeing (McCaughy Centre), p.8.

42 *Transcript of evidence 24*, Associate Professor Anthony LaMontagne—VicHealth Centre for the Promotion of Mental Health and Community Wellbeing (McCaughy Centre), p.6.

These resources provide examples of workplace bullying and job stress. They also detail risk management processes that organisations should adopt to reduce, control and respond to the risk of bullying and job stress within the workplace. The Committee determined that these resources need to be more actively promoted to employers and health and safety representatives.

→ **RECOMMENDATION 7.1:**

That through WorkSafe, the Victorian Government works with relevant stakeholders across Victoria to:

- Increase awareness among employers on understanding and responding to work risks to mental health, including job stress and bullying.
- Encourage organisations to review and update their policies and procedures relating to job stress and bullying.

7.3 Early intervention to help employees stay well

The Committee considered that early intervention measures can be of significant benefit in responding to the emergence of mental health issues in workplaces and in assisting employees to stay well and maintain their employment.

Early intervention involves assisting employees before symptoms develop into more serious mental health problems or injuries.⁴³ It is of benefit to both employees and employers. Early intervention can prevent an employee from becoming mentally unwell and taking long-term sick leave. This can assist in avoiding the need to seek compensation. For employers, early intervention can help to improve performance within the workplace and avoid productivity losses associated with work absences and employee turnover. This applies to workers experiencing mental health issues that are related to their work such as job stress, as well as employees with pre-existing mental illness who show signs of a decline in their health.

Examples of early intervention initiatives for employees experiencing mental health issues in the workplace include stress management programs and EAPs.

Research evidence suggests that stress management programs can assist employees in coping with psychosocial hazards in the workplace. This can help employees to remain well and reduce the risk of mental injury or stress related work absences.

- Work-oriented cognitive behavioural therapy programs have been shown to help employees on stress-related sick leave to return to work more quickly, reducing their risk of long-term unemployment.⁴⁴
- Exploratory studies suggest that mindfulness training programs can help to reduce stress-related illnesses among employees such as anxiety, eating disorders, and depression.⁴⁵ These are a form of cognitive behavioural therapy (CBT).

43 Comcare (2010) *Early intervention to support psychological health and wellbeing*. Canberra, Comcare, Commonwealth of Australia, p.1.

44 Lagerveld, S.E., Blonk, R.W.B., Brenninkmeijer, V. et al. (2012) 'Work-focused treatment of common mental disorders and return to work: A comparative outcome study'. *Journal of Occupational Health Psychology*, Vol. 17, No. 2, pp.220-34, p.226.

45 Klatt, M.D., Buckworth, J., & Malarkey, W.B. (2008) 'Effects of low-dose mindfulness-based stress reduction (MBSER-ld) on working adults'. *Health Education and Behaviour*, Vol. XX, No. X, pp.1-13, p.2.

The Committee identified a role for WorkSafe Victoria in working with relevant stakeholders to highlight the case for early intervention and its benefits for reducing the productivity and health costs associated with untreated mental illness in the workplace. The promotion of early intervention approaches needs to encourage businesses to ensure they have strategies to manage fatigue and workplace stress. This could include providing counselling support and stress management for employees through EAPs.

→ RECOMMENDATION 7.2:

That through WorkSafe, the Victorian Government works with relevant stakeholders to develop and implement a campaign that highlights:

- The benefits of early intervention when employees display signs of becoming unwell or experience work-related mental health problems.
- The productivity and health costs associated with work stress and other psychosocial hazards.
- The value in workplaces providing counselling support and stress management training.

7.3.1 Employee Assistance Programs (EAPs)

EAPs are employer-funded programs designed to alleviate and assist with the resolution of personal problems that affect workplace performance.⁴⁶ EAPs provide supportive counselling services, usually on a short-term basis. This can include on-site and telephone counselling, as well as referral for psychological symptoms or mental health issues.⁴⁷

Mr Tweedly told the Committee that WorkSafe encourages its claims investigators to make use of EAP 'so that they can deal with the stresses of that particular part of their job'.⁴⁸ The role of claims investigators is to attend the scene of fatalities and major industrial accidents, which can lead to high levels of trauma exposure.

Ms Nowland from Davidson Trahaire Corpsych, a major EAP provider in Australia, informed the Committee that about 30 per cent of employees who access EAP do so for help with dealing with work stress issues related to conflict or workplace bullying.⁴⁹

Inquiry participants suggested that employees with pre-existing mental illness can also benefit from the assistance provided through EAP. For example, in its submission, *beyondblue* identified that EAP services can play a role in identifying flexible work arrangements and workplace adjustments that can assist employees to remain at work during episodes of mental illness:

Workplace-provided psychological support services are also effective mechanisms to improve the capacity of managers and co-workers to respond to the needs of people with a mental illness. Employee Assistance Programs and counselling services can provide guidance and assistance to managers and staff on how to better support a colleague with a mental illness, while also providing support to the person experiencing the mental illness. (emphasis removed)⁵⁰

46 Hargrave, G.E. & Hiatt, D. (2004) 'The EAP treatment of depressed employees: Implications for return on investment'. *Employee Assistance Quarterly*, Vol. 19, No. 4, pp.39-49, p.39.

47 Harnois, G. & Gabriel, P. (2000) *Mental health and work: Impact, issues and good practices*. Geneva, World Health Organisation and International Labour Organisation, p.17.

48 *Transcript of evidence 27*, WorkSafe Victoria, p.6.

49 *Transcript of evidence 18*, Davidson Trahaire Corpsych, p.2.

50 *Submission 19, beyondblue*, p.10.

Notably, a study of more than 7,700 employees in the United States (US) who accessed EAP for help with depression between 1997 and 2003 found that the number of employees reporting moderate to severe depressive symptoms following EAP decreased by 48 per cent.⁵¹

Ms Nowland told the Committee that one of the main benefits of EAP for employees experiencing symptoms of mental illness is the speed at which psychological services can be accessed through EAP:

Because the emphasis is on self-referral, people can ring us to obtain counselling very quickly. The average wait time for an appointment with a psychologist if you are accessing them through the better outcomes funding program, is probably two weeks if you are lucky, but obviously it can be longer. We guarantee appointments within two working days, and we can provide telephone intervention—and this is across the EAP sector—within 20 minutes if there is an emergency.

Given that early intervention is quite critical in helping people maintain their employment, we can actually facilitate that easy access to counselling fairly quickly.⁵²

Witnesses in the House of Representatives Standing Committee on Education and Employment Inquiry into mental health and workforce participation (the 'Federal Inquiry') expressed concern that some businesses may view EAP as all that is needed to assist employees experiencing mental health issues. Mr Bo Li, Senior Policy Advisor on Professional Practice for the Australian Psychological Society, explained that 'it is unfortunate that employers see EAP as a way of outsourcing their responsibilities.'⁵³ Similarly, Dr Caryl Barnes, Consultant Psychiatrist with the Black Dog Institute, told the Federal Inquiry that:

The problem is if people think they have fixed it by sending the employee to 10 sessions of EAP and they do not have to handle it anymore, and say 'You should be fixed now' ... that can be unhelpful.⁵⁴

This view was shared by Mr McNair from Mental Health @ Work in evidence presented to this Inquiry. Mr McNair told the Committee that 'EAP is a wonderful mechanism, but unfortunately ... there is no one silver bullet.'⁵⁵ The Managing Director of Mental Health @ Work, Ms Ingrid Ozols, also emphasised that 'EAP providers ... are not a regulated industry.'⁵⁶ Consequently, the types of support and interventions that EAP providers deliver for employees presenting with mental health issues may differ between providers.

The Committee heard that EAP providers may not always identify that employees who use their services have mental illness. For example, Ms Nowland told the Committee that EAP providers often use a case management approach where 'if somebody presents with a condition which requires a long-term intervention, they are referred on [to specialist treatment services].'⁵⁷ However, she told the Committee that most EAP providers do not administer any form of diagnostic assessment to determine whether employees who use the service satisfy the criteria for diagnosable mental illness. She

51 Hargrave & Hiatt (2004) 'The EAP treatment of depressed employees: Implications for return on investment', p.41.

52 *Transcript of evidence 18*, Davidson Trahaire Corpsych, p.3.

53 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*. Canberra, Parliament of the Commonwealth of Australia, p.123.

54 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*, p.123.

55 *Transcript of evidence 19*, Mental Health @ Work, p.4.

56 *Transcript of evidence 19*, Mental Health @ Work, p.7.

57 *Transcript of evidence 18*, Davidson Trahaire Corpsych, p.2.

explained that this is because carrying out assessments ‘takes time to administer ... and it is something that could potentially inflate the cost of the EAP to the customer.’⁵⁸

The Committee determined that EAP can potentially provide valuable early intervention and support to help employees stay well. However, it considered that best-practice guidelines for responding to employees presenting with mental health related issues need to be developed and implemented across the industry. The Committee also recognises that EAP is not a substitute for initiatives to create mentally-healthy and supportive workplace cultures in which employers and employees feel comfortable disclosing and discussing mental health issues. It considers nonetheless that the Victorian Government, through WorkSafe, could work with employer groups and industry associations to promote the value of EAP and related psychological services to businesses.

The Committee recognises that small businesses have limited resources to invest in promoting the mental health of their workers and require assistance to implement early intervention programs. In particular, the Committee heard that very few small businesses have the capacity to purchase EAP services for their employees.⁵⁹

FINDING 5

That Employee Assistance Programs (EAP) are independent of the workers compensation system but can assist in early identification of mental health issues and in providing guidance to employees and managers on workplace adjustments and strategies that can assist in maintaining employment.

FINDING 6

That to ensure consistent delivery of EAP interventions, industry standards are needed.

→ RECOMMENDATION 7.3:

That through WorkSafe, the Victorian Government partners with relevant stakeholders such as *beyondblue* and Employee Assistance Program (EAP) providers to:

- Develop industry-wide standards for responding to and supporting employees that present with mental health related issues.
- Increase awareness among employers of effective services such as EAP that can assist employees and workplaces in managing the impacts of mental illness.

7.3.2 Work health checks

Inquiry participants identified WorkSafe’s *Work health checks* initiative as a potential way to contribute to the earlier identification and prevention of mental illness within the workplace.⁶⁰ While originally designed for physical health factors, the Committee heard the checks have potential for mental health.

⁵⁸ *Transcript of evidence 18*, Davidson Trahaire Corpsych, p.5.

⁵⁹ *Transcript of evidence 18*, Davidson Trahaire Corpsych, p.6.

⁶⁰ *Submission 19*, *beyondblue*, p.8.

Box 7.2 WorkSafe Work health checks

Work Health checks have been delivered by WorkSafe since 2008 as part of its Work Health program to reduce the prevalence of lifestyle risk factors for type-2 diabetes and cardiovascular disease. The 15-minute health checks are available free-of-charge to all Victorian workers and are provided on a confidential basis.

Through the checks, workers receive advice about what they can do to improve their health, while those who are identified as being at risk of developing type-2 diabetes and/or cardiovascular disease are provided with additional support and access to approved programs.⁶¹

Source: Compiled by Family and Community Development Committee.

In its submission, *beyondblue* suggested that there is an opportunity for the Victorian Government to integrate mental health into the *Work health checks* initiative operated by WorkSafe. *Beyondblue* identified that *Work health checks* currently do not check for depression and anxiety. This is despite:

The high prevalence of these conditions; the cost of depression and anxiety for both the Government and employers; and the relationship between psychosocial work conditions and mental health.⁶²

Beyondblue also highlighted that ‘there are strong relationships between the chronic illnesses that the Work health checks initiative screens for ... and depression and anxiety disorders.’⁶³

WorkSafe advised the Committee that it had decided against including depression and anxiety in the *Work health checks*. The key reason included concerns about whether workers would participate in the checks if information on mental health was collected. WorkSafe felt it could only include mental health once Victorian workers were confident that their health information would be kept confidential from employers.

Mr Tweedly told the Committee that WorkSafe may now be in a position to include mental health measures within *Work health checks*:

We debated long and hard about whether or not we would incorporate a mental illness measure as part of it. We choose not to go that pathway I think partially because the privacy issue was still sitting there ... and we had to have a track record of privacy being maintained. We now have that. Now nearing 500,000 Victorian employees have had a health check ... All that privacy has been protected, and so maybe there is an opportunity to expand it into the medical mental wellbeing area in the future.⁶⁴

The Committee identified that including mental health risk factors within *Work health checks* could assist early identification and the provision of advice and treatment options for employees experiencing symptoms of mental illness.

Participants suggested this would be of benefit in addressing non-work related mental health problems as well as those linked to stressful experiences in the workplace. For example, *beyondblue* suggested that:

It is vital that screening for depression and anxiety disorders are incorporated into

61 WorkSafe Victoria (2010) *Working towards better health: WorkHealth strategic framework 2010-2012*. Melbourne, WorkSafe Victoria, p.4.

62 *Submission 19, beyondblue*, p.8.

63 *Submission 19, beyondblue*, p.8.

64 *Transcript of evidence 27*, WorkSafe Victoria, pp.7-8.

the Work health checks initiative, to ensure that the advice and treatment options provided to people through the program is appropriate, holistic, and considers the impact of mental health problems on physical health and wellbeing, and the ability to respond to treatment and lifestyle advice.⁶⁵

WorkSafe indicated that incorporating mental health measures within the checks could also gather statistical data that could be used to advise businesses on how they can improve the wellbeing of their employees. For example, the existing data on employee health that is gathered through *Work health checks* is examined by WorkSafe, in conjunction with researchers at Monash University, to identify patterns in employee physical wellbeing. This information is then used to provide advice to employers on what they can do at an organisational level to improve employee health.⁶⁶

In view of WorkSafe's original concerns about employee privacy, the Committee determined that a pilot study is needed to evaluate the feasibility of including mental health screening within *Work health checks*.

→ **RECOMMENDATION 7.4:**

That the Victorian Government commissions a pilot study to evaluate the feasibility, and benefits of, including mental health problems into WorkSafe *Work health checks*.

7.3.3 Peer support

Participants suggested that peer support networks can also be valuable in assisting employees with mental illness to stay well and in facilitating early identification and intervention of mental health issues among employees.

Studies of the experiences of employees living with mental illness suggest that sharing experiences with peers engaged in similar struggles can provide inspiration and non-threatening support during times of difficulty.⁶⁷ In its submission, the VMHCN stated that 'sharing experiences with peers can be most helpful in preventing problems, overcoming difficulties and building confidence.'⁶⁸

A number of Inquiry participants, including *beyondblue*, suggested a role for peer support programs in helping people with mental illness to remain at work. They cited the example of Open Minds, the peer directed network for Victorian Public Service (VPS) employees with mental illness or caring for someone with mental illness (see Box 7.3).⁶⁹

65 Submission 19, *beyondblue*, p.8.

66 Transcript of evidence 27, WorkSafe Victoria, p.8.

67 Fossey, E. & Harvey, C. 'Finding and sustaining employment: A qualitative meta-synthesis of mental health consumer views'. *Canadian Journal of Occupational Therapy*, Vol. 77, No. 5, pp.303-14, p.310.

68 Submission 26, Victorian Mental Health Carers Network, p.9.

69 Submission 19, *beyondblue*, p.11; Submission 26, Victorian Mental Health Carers Network, p.9.

Box 7.3 Open Minds

Open Minds was established in February 2010 with funding from the Victorian Public Service (VPS) Human Resources Director's Network and the Department of Health. It is now hosted by the Department of Transport, with financial support from across all VPS departments.⁷⁰

The network is co-convened by Ms Maria Katsonis from the Department of Premier and Cabinet and Ms Sally Gibson from the Office of the Public Advocate. Both have first-hand experience of mental illness (one as a consumer, the other as a carer).

In 2010, about 1,000 VPS employees took part in Open Minds activities. These included regular seminars on topics such as 'the lived experience of mental illness', 'let's talk about suicide', 'building resilience' and 'mindfulness'. Open Minds also manages a website where consumers and carers can blog about their experiences.⁷¹

In February 2011, the Nous Group was commissioned by *beyondblue* and Open Minds to conduct an evaluation of Open Minds' programs. Overall, the evaluation found that Open Minds has enabled a substantial number of program participants 'to talk more confidently and openly with their colleagues about their mental health issues.'⁷²

For many participants, Open Minds provided a first opportunity to talk about mental health issues and seek assistance. In its submission, Open Minds included feedback from a number of program participants:

- 'I feel less alone because I know that there are others across the VPS who are experiencing similar things to what I have experienced.'⁷³
- 'Peer support is an important element. Family/carers of people with a mental illness can feel very isolated so meeting peers who are also impacted by mental illness reduces the feeling of isolation.'⁷⁴
- '[I have gained] the personal courage to speak more openly about my own experience, and learning from others in Open Minds.'⁷⁵

Open Minds also invites colleagues and managers of employees with mental illness to participate in activities. It has run mental health first aid training programs and manager training workshops delivered by *beyondblue*.

The majority of managers and colleagues of employees with mental illness who have participated in these activities have identified changes in their knowledge, attitudes and behaviour. In evaluations:

- More than 80 per cent said that they felt more comfortable talking with their colleagues about mental health issues as a result of attending an Open Minds activity.
- Almost 60 per cent said they had talked with colleagues about how their workplace could better support colleagues with mental illness or colleagues caring for someone with mental illness.⁷⁶

Source: Compiled by Family and Community Development Committee.

The Committee considers Open Minds a positive initiative. It encourages the Victorian Government to continue its support of Open Minds and to consider how similar peer support programs could be promoted within the private sector.

70 The Nous Group (2011) *Evaluation of Open Minds*. Melbourne, Open Minds, p.5.

71 The Nous Group (2011) *Evaluation of Open Minds*, p.10.

72 *Submission 16*, Open Minds, p.4.

73 *Submission 16*, Open Minds, p.5.

74 *Submission 16*, Open Minds, p.5.

75 *Submission 16*, Open Minds, p.5.

76 *Submission 16*, Open Minds, p.4.

FINDING 7

That peer support programs are valuable in assisting people with mental illness to participate in employment.

7.4 Supporting employees when they become unwell

Many Inquiry participants raised the importance of supporting people with mental illness to maintain their employment when they become unwell.

As noted earlier, many people with mental illness are participating in the workforce even though the overall rate of workforce participation among people with mental illness is low. A consistent message from stakeholders during the Inquiry was that supporting these people to maintain their employment during times when they are unwell is critical to achieving sustained improvement in workforce participation by people with mental illness.

For example, Mr Kevin Robbie, Executive Director and Team Leader of Employment at Social Ventures Australia (SVA), expressed the view that:

Probably a lot of people with mental illness fall out of the labour market because there is not a lot of work done to retain them ... If you have this pool [of people not participating in the workforce] that is a problem, the first thing you want to do is try to stop the pool getting any bigger.⁷⁷

Due to the episodic nature of mental illness, there may be times when people 'require a temporary scaling down of demands, additional supervision, or reduced hours to enable them to continue in work through difficult periods.'⁷⁸

For example, in its submission, SANE highlighted that 'people affected by mental illness may have times when they need flexibility, such as being able to work part-time, work from home at times, or have workplace adjustments made.'⁷⁹ The VMHCN similarly highlighted the importance of providing flexibility, including additional leave arrangements, 'so that episodes of illness can be accommodated ... [and] to allow consumers to attend and carers to assist at mental or other treatment appointments.'⁸⁰

The Committee identified that underlying the provision of flexibility is the importance of mental health literacy within workplaces and the value of understanding and supportive managers.

Beyondblue informed the Committee that that 'the support of the manager or supervisor is the most strongly associated factor in successful job retention of people who experience mental illness.'⁸¹ (emphasis removed) This view was echoed by SANE, which stated that 'improved understanding of, and attitudes towards, mental illness by employers is a major factor in helping those affected to successfully get and keep a job.'⁸² Indeed, participants in a survey of 284 people with mental illness

77 *Transcript of evidence 22*, Social Ventures Australia, 7 March 2012, p.6.

78 Perkins, R., Farmer, P., & Litchfield, P. (2009) *Realising ambitions: Better employment support for people with a mental health condition—A review to government*. London, Disability and Work Division, United Kingdom Government Department for Work and Pensions, p.29.

79 *Submission 7*, SANE, p.6. See also SANE (2011) *Research bulletin 14: Working life and mental illness*, p.2.

80 *Submission 26*, Victorian Mental Health Carers Network, p.7.

81 *Submission 19, beyondblue*, p.10.

82 *Submission 7*, SANE, p.1.

commissioned by SANE in 2006 rated support from their employer as the most important factor in successful employment.⁸³

FINDING 8

That support from employers is the most important factor in successful employment of people with mental illness

The Committee determined that workplace mental health literacy training programs, discussed in Chapter 6, play an important role in increasing understanding of mental illness in workplaces and in assisting workplaces to provide flexibility to support employees when they become unwell.

Mission Australia indicated that a work environment that promotes awareness and understanding of mental health issues ‘can have a powerful role to play in supporting employees to seek support if required and to remain engaged in employment.’⁸⁴ Similarly, Mr McNair from Mental Health @ Work told the Committee that ‘if you have got a healthy workplace where it is okay to talk about these issues, the chances of seeking help and support in the workplace is extremely high.’⁸⁵

The Committee considered that countering negative perceptions and stigma associated with mental illness in the workplace is also important in ensuring that people access support when they are unwell. As discussed in Chapter 5, stigma prevents people from disclosing their mental illness within the workplace. This reluctance of people to disclose their mental illness makes the provision of flexibility and support within the workplace very difficult.

Inquiry participants also highlighted the importance of workplaces having effective return-to-work policies.

7.4.1 Effective return-to-work policies

There may be occasions when employees with mental illness experience episodes of severe symptoms that require intensive treatment and time off from work. Following treatment, a gradual return to work may be required before people can resume full work duties.

Inquiry participants indicated to the Committee that the process of returning to work after a mental health-related work absence can be very difficult. For example, the Geelong and Region Trades Hall and Labour Council (GRTHLC) told the Committee that employers need to acknowledge that:

Returning to full working hours is initially often difficult and can be counterproductive to their mental state, but that does not mean they should not be supported ...⁸⁶

Ms Maria Katsonis, Co-Convenor of Open Minds, highlighted ‘the episodic nature of mental illness’ and the ‘tendency for workplaces to treat it the same as a physical

83 *Submission 7*, SANE, p.3. See also SANE (2006) *Research bulletin 3: Employment and mental illness*. Melbourne, SANE, p.1.

84 *Submission 29*, Mission Australia, p.17.

85 *Transcript of evidence 19*, Mental Health @ Work, p.5.

86 *Transcript of evidence 3*, Geelong and Region Trades Hall and Labour Council, 4 November 2011, p.5.

illness.⁸⁷ She suggested that workplaces would benefit from a return-to-work policy specific to the mental health needs of employees. Ms Katsonis explained that:

Returning to work after a severe mental illness is a very different experience to returning with a broken leg or some other tangible evidence that you are returning back to work in a process of recovery.⁸⁸

Ms Nowland explained that when people are returning to work following a mental health-related absence 'there can be a degree of trepidation and anxiety on the part of the person's team members about how they are going to deal with the individual ...'⁸⁹

The Victorian Equal Opportunity and Human Rights Commission (VEOHRC) informed the Committee that one of the most common complaints it receives in relation to employment discrimination against people with mental illness is that some employers 'refuse to consider letting employees with a mental illness who have been on sick leave return to work on reduced duties or before they are fully recovered.'⁹⁰

The Committee considers that return-to-work guidelines for employees who have taken leave for reasons relating to mental illness need to be developed and promoted to employers. The guidelines should address:

- expectations, roles and responsibilities of all parties involved in the return-to-work process
- the importance of returning to work for the employee's recovery
- procedures for keeping in contact with employees who have taken leave for reasons relating to mental illness
- where employers and return-to-work coordinators can go to for support in making reasonable adjustments to support an employee to quickly return to work
- managing the disclosure of mental illness within the workplace and employer's duty of care to protect the privacy and confidentiality of a worker who discloses that they have mental illness
- responsibilities within organisations for putting return-to-work plans into action.⁹¹

The mechanisms promoted by WorkSafe to support employees' return to work following a work-related injury could be adapted for this purpose, taking account of the particular support needs of employees recovering from mental illness.

WorkSafe requires employers to consult with injured workers for a period of 52-weeks and they must keep a suitable job open for that individual to come back to work. They are also obliged to appoint a return-to-work coordinator within their business to assist the individual to get back to work and they are required to provide information to workers about return-to-work throughout that period.

The Committee understands that WorkSafe has previously partnered with *beyondblue* to develop guidelines on supporting the return-to-work of employees with depression

87 *Transcript of evidence 8*, Open Minds, 21 November 2011, p.4.

88 *Transcript of evidence 8*, Open Minds, p.3.

89 *Transcript of evidence 18*, Davidson Trahaire Corpsych, p.4.

90 *Submission 41*, Victorian Equal Opportunity and Human Rights Commission, p.11.

91 Adapted from Centre for Youth Mental Health (2011) *Helping employees successfully return to work following depression, anxiety or a related mental health problem: Guidelines for organisations*. Melbourne, University of Melbourne, Accessed on 18 September 2012 from http://www.mhfa.com.au/cms/wp-content/uploads/2012/02/8671_return-to-work_guidelines.pdf.

or anxiety. The University of Melbourne's Centre for Youth Mental Health has also developed guidelines on supporting the return-to-work of employees recovering from depression, anxiety, or related mental illness. These guidelines can be freely downloaded from the Mental Health First Aid website (www.mhfa.com.au).

The Committee considered that the effectiveness of these guidelines in supporting employees' return needs to be evaluated. Effective guidelines also need to be more widely promoted to employers. This could happen as part of a campaign to increase employer awareness of information resources and supports available for workplaces that employ people with mental illness (see Recommendation 6.4).

FINDING 9

That employees returning to work after an episode of mental illness benefit from return-to-work plans specific to mental illness.

→ RECOMMENDATION 7.5:

That the Victorian Government works with relevant stakeholders to:

- Evaluate existing return-to-work guidelines for employees who have taken leave due to mental illness to determine their effectiveness.
- Increase awareness of effective return-to-work guidelines.

Chapter Eight: Strengthening mental health services

Findings

1. That mental health services incorporate a stronger focus on employment and education goals as part of treatment and recovery planning.
2. That partnerships across clinical and non-clinical services are important for achieving education and employment outcomes for people with mental illness.
3. That peer workers can assist people using mental health services to achieve employment goals through sharing experiences, skills and strategies and providing hope as part of their recovery plan.
4. That sector isolation between mental health and employment support services has contributed to a complex service environment that can hinder access to vocational support by people with mental illness.
5. That increased understanding of the employment services system is needed among mental health practitioners to facilitate collaboration and coordination across sectors.
6. That local area networks involving employment support agencies, PDRSS and Area Mental Health Services (AMHS) can help to foster knowledge sharing, collaboration, and referral across the employment support and mental health sectors.
7. That trials reveal locating employment specialists within mental health services using Individual Placement and Support (IPS) principles is the most effective model of vocational support for people with mental illness.
8. That engaging employment specialists within mental health services reduces barriers experienced by people with mental illness accessing vocational support. For example, the difficulties in navigating separate service systems and undergoing lengthy referral and assessment processes.
9. That locating employment specialists within early intervention and youth-focused services may increase the potential to prevent long-term unemployment and its associated personal, economic and health costs.

The Committee heard that mental health services have a critical role in supporting the education and employment goals of people who use their services. It identified that there is value in increasing the focus of mental health services on education and employment goals, particularly those involved in recovery planning for people with mental illness.

As outlined in Chapter 6, one of the key challenges that jobseekers with mental illness confront is negotiating two service systems that can often have incompatible objectives. These are the:

- Commonwealth-funded employment support services system
- State-funded specialist clinical and recovery mental health services.

The Committee heard strong support for greater integration and more complementary objectives across these two systems.

It identified that cross-sector networks can potentially improve joined-up practices across the service systems. These locally based networks aim to facilitate knowledge sharing and actively refer people to agencies across the specialist mental health and employment support service systems.

The Committee found that coordination across sectors is most effective when services are jointly delivered and employment support is integrated with clinical care. In particular, it identified that the location of employment consultants in early intervention services in the mental health sector provide an integrated approach that has the potential to deliver the significant benefits to people with mental illness with education and employment goals.

8.1 Mental health services and vocational pathways

Mental health services have a key role in supporting people with mental illness to achieve education and employment goals as part of a broader treatment or recovery plan.

The Committee identified that mental health services do not always incorporate education or employment goals into the treatment and recovery plans for people who use their services. This is particularly evident in clinical mental health services, which have a stronger focus on treatment over recovery planning.

Participants told the Committee that Psychiatric Disability Rehabilitation and Support Services (PDRSS) have a central role in working towards recovery outcomes. As outlined in Chapter 3, PDRSS include stand-alone mental health services, community health services and community welfare services. The Victorian Mental Health Carers Network (VMHCN) suggested that ‘the PDRS sector in Victoria is ideally placed to provide continuing support for workplace participation.’¹ It also stated that the sector ‘is well-placed to enable clients to attend educational programs.’ This could include ‘facilitating enrolment, encouraging attendance and completion, even attending classes with clients.’²

1 *Submission 26, Victorian Mental Health Carers Network, p.9.*

2 *Submission 26, Victorian Mental Health Carers Network, p.10.*

Inquiry participants indicated strong support for education and employment goals to be considered at every stage in treatment and recovery planning.³ Ms Anthea Tsismetsi, Policy and Research Officer with Psychiatric Disability Rehabilitation Services of Victoria (VICSERV), explained that:

It's really important for a person's recovery that vocational goals be part of their treatment and recovery plan ... This is not just about people getting a job; it's also about giving people a satisfaction of making a living and contributing economically to the world ... Vocational goals need to be strongly emphasised in treatment and recovery plans.⁴

Similarly, the Mental Illness Fellowship of Victoria (MI Fellowship) stated that it sees 'engagement in employment and education as a key component of recovery' for its client group. It explained that 'for many people it is the marker they use to establish that they are in recovery mode, that they are involved in the community and they are socially included.'⁵

As outlined in Chapter 3, in April 2012 the Victorian Government released a consultation paper outlining a framework for reform for the PDRSS sector. The proposed reform framework envisages a stronger role for PDRSS in achieving education and employment outcomes for people with mental illness. This is discussed in Section 8.1.1.

8.1.1 Recovery planning and vocational outcomes

The focus on education and employment outcomes for people who use mental health services reflects a broader move towards a recovery-oriented focus in mental health service delivery.

Dr Tom Callaly, Executive Director of Mental Health Services at Barwon Health, stated that:

In Victoria and worldwide public mental health services are attempting to move their orientation towards what is called recovery focus. A recovery focus involves quite a number of challenges, but basically it acknowledges and respects the individual's own path and desires and is much more holistic in approach.⁶

The Department of Health's (DoH) *Framework for Recovery-Oriented Practice* states that a recovery-focus involves 'a holistic approach to wellbeing that builds on individual strengths ... emphasises hope, social inclusion, community participation, personal goal setting and self-management.'⁷ Waghorn and Lloyd suggest that 'vocational rehabilitation is ideally suited to a recovery framework' because:

Many of the goals of rehabilitation are best served by addressing the person's vocational aspirations. Employment contributes to the recovery process through being perceived as a means of self-empowerment, and by promoting a sense of self-actualisation.⁸

3 *Submission 15*, Prahran Mission UnitingCare, p.7; *Submission 26*, Victorian Mental Health Carers Network, p.2.

4 *Transcript of evidence 6*, Psychiatric Disability Services Victoria (VICSERV) & Eastern Regions Mental Health Association (ERMHA), 7 November 2011, p.4.

5 *Transcript of evidence 25*, Mental Illness Fellowship of Victoria, 7 March 2012, p.2.

6 *Transcript of evidence 1*, Barwon Health & Pathways Rehabilitation and Support Services, 4 November 2011, p.3.

7 Department of Health (2011) *Framework for recovery-oriented practice*. Melbourne, Mental Health, Drugs and Regions Division, Department of Health, State of Victoria, p.2.

8 Waghorn, G. & Lloyd, C. (2005) 'The employment of people with mental illness'. *Australian e-Journal for the Advancement of Mental Health*, Vol. 4, No. 2 (supplement), pp.1-43, p.32.

This research evidence supports the views expressed by many Inquiry participants.

Yet a focus on employment outcomes has not been a traditional focus for mental health services. Ms Laura Collister, General Manager of Rehabilitation Services at the MI Fellowship, explained that mental health services tend to focus ‘on treatment and illness, so they do not see getting people work as part of their business.’⁹

In addition, perceptions of mental health practitioners about the capacity of people who use their services are critical in determining how they approach education and employment goals. In 2007, the Mental Health Council of Australia (MHCA) identified that ‘low expectations of people with mental illness may occur among the mental health workforce and other health professionals as well as with employers.’¹⁰ Prahran Mission told the Committee that:

Some clinical workers believe that people with a mental illness cannot and will never be employed and therefore will not work towards this goal with participants.¹¹

Orygen Youth Health (OYH) explained that a view persists among some mental health practitioners ‘that employment will be too stressful for people with mental ill-health ...’¹²

In research commissioned as part of the Commonwealth Government’s *National mental health strategy*, several studies are cited that show low expectations result in few people who use mental health services being asked about their vocational interests.¹³ This is consistent with findings in a 2011 MHCA study on consumer and carer experiences of stigma from health professionals. The study found that more than a third of people who use mental health services who participated in the study said they had been advised by the person treating them to lower their expectations for accomplishments in life. For those with psychosis the figure was even higher (55 per cent).¹⁴

In his submission, Dr Geoff Waghorn from the Queensland Centre for Mental Health Research identified that while mental health services can promote the value of pursuing vocational goals in treatment and recovery planning:

This [requires] taking proactive steps to reduce the stigma of low expectations, common in health and rehabilitation services that currently hinders the timely referral of clients to suitable disability employment services.¹⁵

The Committee identified that these steps need to include education for mental health practitioners in line with broad mental health reforms in Victoria and those specifically related to the PDRSS sector (see section 8.1.3).

FINDING 1

That mental health services incorporate a stronger focus on employment and education goals as part of treatment and recovery planning.

9 Transcript of evidence 25, Mental Illness Fellowship of Victoria, p.8.

10 Mental Health Council of Australia (2007) *Let’s get to work: A national mental health employment strategy for Australia*. Mental Health Council of Australia, p.33.

11 Submission 15, Prahran Mission UnitingCare, p.3.

12 Submission 18, Orygen Youth Health, p.5.

13 Cited in Frost, B., Carr, V., & Halpin, S. (2002) *Employment and psychosis: A bulletin of the low prevalence disorders study group*, report for the Department of Health and Ageing, Commonwealth of Australia, p.14.

14 Mental Health Council of Australia (2011) *Consumer and carer experiences of stigma from mental health and other health professionals*. Canberra, MHCA, pp.16, 26.

15 Submission 42, Dr Geoff Waghorn—Queensland Centre for Mental Health Research, p.6.

→ RECOMMENDATION 8.1:

That as part of the reforms to the mental health sector, the Victorian Government develops a professional development program for mental health practitioners to increase understanding of the importance of workforce participation in recovery for people with mental illness.

8.1.2 Partnerships across mental health services

To achieve the recovery focus required for improving workforce participation by people with mental illness, the Committee also identified the importance of partnerships between clinical and non-clinical mental health services. Dr Callaly explained that over the past five or six years:

Instead of being isolated and just taking care of the person's severe illness phase, which might often be months or even years, of an acute episode of psychosis—instead of just focusing on treating that medically, all public mental health services have had a much greater focus on forming partnerships.¹⁶

VICSERV also emphasised the importance of partnerships and linkages across services for achieving education and employment outcomes for people with mental illness.¹⁷

Mr Mark Rosser, Program Development Manager at Pathways Rehabilitation and Support Service, further explained the importance of these partnerships:

Our journey really is when the clinical teams and the clinical work is completed or in process, but being completed; then we take over...It is very much the case that when someone experiences mental illness, they really need support in two areas—one in the clinical world and then one in the psychosocial world, which is all the other everyday aspects of their life that need to be addressed.¹⁸

Dr Callaly explained that clinical services may not have the expertise to support the vocational recovery of people with mental illness and that partnering with Pathways has been very important in 'effectively introduc[ing] our clients into a situation where they are going to get support for entering social and occupational activity.'¹⁹

FINDING 2

That partnerships across clinical and non-clinical services are important for achieving education and employment outcomes for people with mental illness.

8.1.3 Proposed reforms to PDRSS

In April 2012, the Victorian Government proposed a framework for reforming the structure and funding of PDRSS programs. The framework proposes a shift from program-focused services towards person-centred support.²⁰ The Victorian Government is also considering refocusing the role of PDRSS to provide 'more direct

16 *Transcript of evidence 1*, Barwon Health & Pathways Rehabilitation and Support Services, pp.2-3.

17 *Transcript of evidence 6*, Psychiatric Disability Services Victoria (VICSERV) & Eastern Regions Mental Health Association (ERMHA), p.4.

18 *Transcript of evidence 1*, Barwon Health & Pathways Rehabilitation and Support Services, p.3.

19 *Transcript of evidence 1*, Barwon Health & Pathways Rehabilitation and Support Services, p.3.

20 Department of Health (2012) *Psychiatric Disability Rehabilitation and Support Services reform framework: Consultation paper*. Melbourne, Department of Health, State of Victoria, p.2.

and explicit support for social and economic participation to better support people in their recovery journey.²¹

The Committee identified examples of how PDRSS providers already support people who use mental health services to transition to employment. These include social firms and related employment pathways. Chapter 6 discussed these initiatives in detail. Briefly, Mr Rosser from Pathways explained that its program works to ‘make sure that the individual support plans that we wrap around the approximately 700 people that we see in the Barwon region every year targets employment, education, training and all those things that they want to achieve.’²²

The Consultation Paper released by the Victorian Government was based on a review conducted by the Nous Group in 2011. The Nous Group review recommended that:

- programs be reoriented to deliver an agreed set of client-focused outcomes with a greater focus on mental and physical health, economic participation through education and employment, and social participation
- service provider performance and funding be linked to achieving client outcomes in the areas in the above dot-point
- service providers adopt evidenced-based service delivery models
- services be required to develop stronger and more active partnerships and coordination mechanisms with local services covering education, employment, housing, recreation, community services, health, and clinical mental health services.²³

The Committee acknowledges that work in reforming the PDRSS sector is already underway. It suggests that in undertaking these reforms, the Victorian Government introduces clear accountabilities for achieving education and employment goals.

The Committee determined that linking program funding to a set of client-outcomes that includes participation in education and employment, and requiring providers to report against these outcomes, would encourage more providers to implement evidence-based approaches to support the vocational rehabilitation of people with mental illness.

→ **RECOMMENDATION 8.2:**

That as part of the Psychiatric Disability Rehabilitation and Support Services (PDRSS) reform framework, the Victorian Government establishes clear targets for achieving education and employment goals, including developing sector standards and linking funding to evidence-based care models.

8.1.4 Increasing involvement of peer workers

A number of Inquiry participants suggested that including peer workers as part of mental health services teams could help to encourage people with mental illness and clinical staff to focus on employment goals in recovery planning.

21 Department of Health (2012) *Psychiatric Disability Rehabilitation and Support Services reform framework: Consultation paper*, p.19.

22 *Transcript of evidence 1*, Barwon Health & Pathways Rehabilitation and Support Services, p.4.

23 Department of Health (2012) *Psychiatric Disability Rehabilitation and Support Services reform framework: Consultation paper*, p.28.

A peer worker is ‘someone with a “lived experience of mental illness” who uses this experience to support other consumers and foster hope.’²⁴ The *Fourth national mental health plan* identifies that increasing the employment of people with mental illness within clinical and community support teams is central to cultivating a recovery-oriented culture within mental health services.²⁵ Research consistently shows that direct contact with people with lived experience of mental illness is ‘the most effective means of producing long-lasting and sustained improvement in public attitudes.’²⁶

Peer workers can help to challenge clinicians’ beliefs about the capacity of people with mental illness to engage in work. In a review of the benefits of peer support and peer directed services, one researcher highlighted that:

Peer providers give mental health providers the opportunity to see peers successfully functioning in productive, ‘normal’ social roles. Peer providers further offer mental health providers the opportunity to relate to individuals with psychiatric diagnoses as peers. These types of situations help to combat societal stigma of persons with severe mental illness.²⁷

The Committee heard that peer workers, through their own example of recovery, can also help people with mental health to overcome anxieties that they may have about entering or returning to employment. As Associate Professor Carol Harvey from the Psychosocial Research Centre (PRC) told the Committee:

The peers have learnt how to manage stress, their symptoms, their medication and the workplace effectively through self-management, and they can help people coming along who have not yet got to that point to work through the same issues.²⁸

She spoke, in particular, about the role of peer workers in delivering psycho-educational programs in which participants learn about managing their mental illness when returning to work or study. She cited the example of the Health Optimisation Program for Employment (HOPE).²⁹ This is discussed in Box 8.1.

24 Streater, M. (2010) ‘The peer worker experience’. *newparadigm: The Australian Journal on Psychosocial Rehabilitation*, Vol. Winter, pp.49-51, p.49.

25 Commonwealth of Australia (2009) *Fourth national mental health plan: An agenda for collaborative government action in mental health 2009-2014*. Canberra, Commonwealth of Australia, p.51.

26 Queensland Alliance for Mental Health (2010) *From discrimination to social inclusion: A review of the literature on anti-stigma initiatives in mental health*. Fortitude Valley, Queensland, Queensland Alliance for Mental Health, p.19.

27 Solomon, P. (2004) ‘Peer support/peer provided services: Underlying processes, benefits and critical ingredients’. *Psychiatric Rehabilitation Journal*, Vol. 27, No. 4, pp.392-401, p.396.

28 *Transcript of evidence 17*, Psychosocial Research Centre, 28 February 2012, p.5.

29 *Transcript of evidence 17*, Psychosocial Research Centre, p.5.

Box 8.1 Health Optimisation Program for Employment (HOPE)

HOPE is a psycho-educational, collaborative therapy program that Social Firms Australia (SoFA) has developed in partnership with St Vincent's Mental Health. From June 2009 until June 2012, it was funded through the Commonwealth Department of Education, Employment and Workplace Relations (DEEWR) Innovation Fund.

The aim of the program is to:

- improve job retention and job search rates among people with mental illness by providing them with the knowledge and coping skills they need to manage their mental health in the context of employment.

The program was developed after SoFA identified that people with mental illness were struggling to maintain job placements for longer than 12 weeks. This was frequently due to challenges in managing their mental health when returning to work.³⁰

The program is:

- delivered in a group setting over a 10-week period
- jointly delivered by a mental health peer educator (someone with lived experience of mental illness) and an employment consultant or clinician.

Participants told the Committee that the role of the mental health peer educator is important in acting as a motivator and positive role model.³¹

According to SoFA, the key outcomes from the program include:

- 200 jobseekers with mental illness had completed HOPE by December 2011³²
- 350 jobseekers were anticipated to complete the program by June 2012³³
- one third of HOPE participants had gone on to find paid employment in the six months following the course
- 15 per cent were engaged in voluntary work after completing the course.³⁴

Source: Compiled by Family and Community Development Committee.

In its submission, Forensicare described the hope that peer workers provide to other people with mental illness that they too can become well enough to work.³⁵ Forensicare is the agency responsible for all forensic mental health services in Victoria. This includes operating in-patient services within the prison system as well as providing community based treatment and care to people who have received a court order for treatment.

Forensicare also operates a community integration program to support people with serious mental illness in their transition back into the community. It explained to the Committee that 'a vital part of this program is supporting clients in their job-seeking endeavours.'³⁶

Forensicare employs five consumer consultants (peer workers) to promote and facilitate consumer participation across its services. These consumer consultants act as mentors to other consumers and liaise with other staff about issues relating to

30 *Transcript of evidence 15*, Social Firms Australia, 28 February 2012, p.4.

31 *Transcript of evidence 17*, Psychosocial Research Centre, p.5.

32 *Submission 43*, Social Firms Australia, p.7.

33 *Transcript of evidence 15*, Social Firms Australia, p.6.

34 *Submission 43*, Social Firms Australia, p.7.

35 *Submission 30*, Forensicare, p.7.

36 *Submission 30*, Forensicare, p.3.

unwell consumers. Forensicare told the Committee that the lived experience these consumer consultants bring to their role is critical:

Their experience with mental illness gives them legitimacy with both consumers and staff—they are able to relate to our patients and clients and be a lived example that a diagnosis of mental illness does not have to mean a lifelong negative existence. They are also able to talk to staff about issues relating to unwell consumers, from the perspective of a consumer who has recovered.³⁷

The Committee shares the view of Inquiry participants that peer workers can be a valuable source of hope and inspiration to other people with mental illness along their journey to recovery. In particular, the Committee notes the support that peer workers can provide to consumers who want to engage in work through peer education programs such as HOPE.

The Committee also considered that peer workers could be engaged to deliver training to the broader mental health workforce in the value of employment in recovery from mental illness (See Recommendation 8.1).

FINDING 3

That peer workers can assist people using mental health services to achieve employment goals through sharing experiences, skills and strategies and providing hope as part of their recovery plan.

→ RECOMMENDATION 8.3:

That, as a priority, the Victorian Government increases the availability of evaluated programs that train peer workers to work in mental health services to provide support to people with mental illness in their recovery and workforce participation.

8.2 Joined-up approaches to service delivery

The Committee identified that more effective collaboration with employment support services is needed if mental health services are to effectively assist people with mental illness in returning to the workforce.

The separation of employment services from specialist mental health services hinders the timely referral of consumers to employment services. It can also lead to the misalignment of treatment and vocational plans.

8.2.1 The importance of inter-sectoral collaboration

Evidence received by the Committee repeatedly identified a need to increase collaboration between specialist mental health and employment services in assisting consumers' workforce participation. This was also highlighted as a critical issue in the House of Representatives Standing Committee on Education and Employment Inquiry into mental health and workforce participation (the 'Federal Inquiry'):

Having effective communication channels between agencies and clients is one very important part of the equation for assisting people with a mental illness to get the

³⁷ Submission 30, Forensicare, p.7.

services they need to find and sustain employment. Another integral component is effective inter-agency communication and coordination.³⁸

The disconnect between the employment services system and the specialist mental health system is widely identified in studies as a major barrier to employment participation among people with mental illness, particularly those with schizophrenia and other psychotic illness. For example, in its *Pathways to social inclusion proposition papers*, VICSERV stated that:

Perhaps the most fundamental indirect barrier to achieving better employment outcomes for people living with severe mental illness lies in sector isolation and its correlates: poor inter-sectoral collaboration, knowledge transfer, and a system that fails those it is intended to support ... When uncoordinated, 'both treatment and vocational plans are at risk of mutual interference, which, at any time, can obstruct progress in both domains and negatively impact on mental health consumers, their families and carers.'³⁹

In his submission, Dr Waghorn explained that 'continued segregation of mental health services from ... employment services continues to limit access to competitive employment by consumers of public mental health services.'⁴⁰ He stated that employment assistance needs to be integrated with continuing mental health treatment and care as 'in the early stages of employment, work performance can be addressed by both training and better treatments.'⁴¹

When mental health services are isolated from employment services, knowledge gaps can develop within each sector that hinder the implementation of evidence-based practices in supporting consumers' vocational rehabilitation. As VICSERV has highlighted:

Clinicians can be unaware of developments in the field of psychiatric vocational rehabilitation, and vocational specialists can be unaware of latest clinical treatments that might address symptoms they regard as employment limitations.⁴²

Inquiry participants suggested that sector isolation has also contributed to a service environment that is 'well-nigh impossible' to navigate for people with mental illness.⁴³ People with mental illness experience lengthy delays in accessing appropriate vocational support as a result. As OYH stated in its submission:

People with mental illness, who are clients of a mental health service and who wish to seek employment, automatically have to negotiate two bureaucratic administrations—the mental health and the employment systems. The difficulty of negotiation is not limited to actually understanding the requirements of each, but may be as simple as overcoming the geographic differences between agencies—i.e. just figuring out where the employment office is and how to get there.

38 House of Representatives Standing Committee on Education and Employment (2012) *Work wanted: Mental health and workforce participation*. Canberra, Parliament of the Commonwealth of Australia, p.209.

39 Psychiatric Disability Services of Victoria (VICSERV) (2008) *Pathways to social inclusion: Proposition papers*. Melbourne, VICSERV, p.79.

40 *Submission 42*, Dr Geoff Waghorn—Queensland Centre for Mental Health Research, p.7.

41 *Submission 42*, Dr Geoff Waghorn—Queensland Centre for Mental Health Research, p.7.

42 Psychiatric Disability Services of Victoria (VICSERV) (2008) *Pathways to social inclusion: Proposition papers*, p.79. See also Waghorn & Lloyd (2005) 'The employment of people with mental illness', pp.4-5.

43 *Transcript of evidence 11*, Professor David Castle—Chair of Psychiatry, St Vincent's Hospital Melbourne, 24 February 2012, p.2.

This difficulty is compounded by poor to non-existent co-ordination between mental health and employment systems. The two different systems have two sets of priorities which are not always in alignment and not always well communicated.⁴⁴

FINDING 4

That sector isolation between mental health and employment support services has contributed to a complex service environment that can hinder access to vocational support by people with mental illness.

8.2.2 Increasing awareness across sectors

The Committee heard that poor working knowledge of the employment services system among mental health practitioners and vice versa can compound the difficulties that mental health consumers experience in accessing support. For example, in its submission, the PRC suggested that:

The complexity of funding arrangements and programs within mental health services and disability employment services make it difficult for staff in each sector to understand the working arrangements of the other, which acts as a barrier to collaboration and ensuring people with mental ill health get appropriate assistance.⁴⁵

Associate Professor Harvey elaborated upon this issue during Inquiry hearings. She told the Committee that, to achieve a coordinated approach to service delivery, increased knowledge and understanding is needed across the sectors:

The evidence-based model is that mental health expertise and employment expertise need to come together, and the people with those respective expertises need to be working together for the benefit of the person who is trying to find employment. What we have got operating is a federally-funded system of disability employment services and the mental health services which are predominantly state-funded, and they often do not talk to each other or know about each other. I would say also, in brackets, that the professions have fallen down—and I will include myself in it although I do my best to address this—in terms of the awareness, training and skills of our mental health workers ... and around the need to have expertise in this area, to know about the disability employment sector and to actually work with our colleagues in that sector.⁴⁶

In its submission, *beyondblue* similarly identified limited understanding of the employment services system as a barrier to health services supporting the vocational goals of people with mental illness:

Research suggests that there are a number of barriers to health and community services in supporting workforce participation, which include difficulties in understanding and navigating the employment support system.⁴⁷

FINDING 5

That increased understanding of the employment services system is needed among mental health practitioners to facilitate collaboration and coordination across sectors

44 Submission 18, Orygen Youth Health, pp.3-4.

45 Submission 37, Psychosocial Research Centre, p.3.

46 Transcript of evidence 17, Psychosocial Research Centre, p.4.

47 Submission 19, *beyondblue*, p.12.

Developing local partnerships

The Committee heard that the ‘provision of opportunities for staff from DES [Disability Employment Services] and AMHS [Area Mental Health Services] to network, communicate and collaborate is essential if good vocational outcomes are to be secured for people with significant mental illness.’⁴⁸ The Committee identified scope for establishing local networks to facilitate inter-agency referral and knowledge sharing.

Through creating opportunities for service providers from across sectors to come together for professional development activities, local area networks can promote understanding of the roles of different sectors in supporting employment participation by people with mental illness, as well as how to access services. For example, during the Inquiry, the Committee heard about how Local Employment Access Partnerships (LEAP) piloted by SoFA have fostered linkages between AMHS, PDRSS, and DES. Box 8.2 outlines these partnerships in more detail.

Box 8.2 Local Employment Access Partnerships (LEAP)

From June 2009 until June 2012, Social Firms Australia (SoFA) received funding through the Commonwealth Department of Education, Employment, and Workplace Relations (DEEWR) to develop LEAP partnerships in six areas in Victoria. These were Coburg, Footscray, Northcote, Prahran, Dandenong and Maryborough/Bendigo.⁴⁹

LEAP partnerships seek to address the gap between mental health and employment services by creating opportunities for agencies and staff working in the different sectors to network, communicate, and collaborate on a regular basis.

Partnerships meet quarterly and include Psychiatric Disability Rehabilitation Support Services, Area Mental Health Services (AMHS), neighbourhood and urban renewal agencies, and Disability Employment Services (DES). Through the partnerships, agencies have sought to improve their understanding of their respective roles, increase agency referrals, and share and promote service development.⁵⁰ Agencies have also collaborated to deliver the Health Optimisation Program for Employment (HOPE) (see Box 8.1).

In its submission, SoFA described how the partnerships have benefited jobseekers with mental illness:

- A DES client became quickly unwell and began displaying symptoms of suicidal thoughts. Through a relationship formed in the LEAP partnership, the DES worker was able to seek expert clinical advice which resulted in the client receiving appropriate assessment and treatment from an AMHS.
- A clinician wrongly believed that if her client undertook paid employment the client would lose their disability support pension. DES staff were able to explain that her client could work part-time without losing benefits.
- A DES client who experienced ongoing disruptive symptoms relating to his mental illness was having difficulties retaining work. Through discussions, clinical staff were able to generate a number of strategies that could be utilised in the workplace to better accommodate his health issues.⁵¹

Source: Compiled by Family and Community Development Committee.

The Committee considered that inter-sectoral local area partnerships similar to LEAP could be fostered through existing Community Mental Health Planning and Service Coordination Initiatives. These are cross-sector mental health planning and

48 *Submission 43*, Social Firms Australia, p.8.

49 *Submission 43*, Social Firms Australia, p.5.

50 *Submission 43*, Social Firms Australia, p.5.

51 *Submission 43*, Social Firms Australia, p.8.

coordination partnerships that have been established within each DoH region. They include representation from a range of service sector agencies, including employment support providers, AMHS, PDRSS, as well as consumer and carer groups. Their aim is 'to ensure that people with mental health problems are cared for in a well-connected and comprehensive way and do not fall between gaps in service systems.'⁵² Mental Health System Development Managers within each DoH region have been funded to support the development and activity of these initiatives.

Community Mental Health Planning and Service Coordination Initiatives have a broader focus than brokering linkages between employment services and the specialist mental health system. Nonetheless, the Committee recognises that they provide an avenue for mental health, employment and other related services to network at a local level to increase understanding and collaboration across sectors.

The Committee noted that some initiatives have already prioritised the development of closer linkages between mental health and employment services as a key coordination issue in their region.

For example, the Committee received a submission from the Barwon South Western Community Mental Health Planning and Service Coordination Initiative.⁵³ The Barwon South Western initiative has decided to focus on mental health and employment as one of four service coordination priorities. A working group on mental health and employment has been established. It includes the DoH, Barwon headspace, and Barwon AMHS as well as the MI Fellowship and Pathways Rehabilitation and Support Services (both of which provide support to people with mental illness to find employment).

The working group holds forums to bring mental health and employment services together to share knowledge, discuss best practice models of employment support for people with mental illness, and discuss and decide on formal ways for the sectors to work together. The Committee also understands that the working group is considering a regional partnership between a clinical mental health service and an employment service to deliver integrated mental health and employment assistance services from a single site.

The Committee considered that the development of local partnerships between specialist mental health and employment support services should be prioritised across Community Mental Health Planning and Service Coordination Initiatives as a matter of urgency. This should include establishing a leadership role within initiatives to ensure that ongoing collaboration with employment support services is embedded within the practice of mental health services.

FINDING 6

That local area networks involving employment support agencies, Psychiatric Disability Rehabilitation and Support Services (PDRSS) and Area Mental Health Services (AMHS) can help to foster knowledge sharing, collaboration, and referral across the employment support and mental health sectors.

52 Department of Human Services (2009) *Because mental health matters: Victorian mental health reform strategy 2009-2019*. Melbourne, Mental Health and Drugs Division, Department of Human Services, State of Victoria, p.138.

53 *Submission 38, Mental Health and Employment Working Group of the Barwon South Western Region Community Mental Health Planning and Service Coordination Initiative.*

→ RECOMMENDATION 8.4:

That through Community Mental Health Planning and Service Coordination Initiatives, the Victorian Government prioritises the development of more local partnerships between specialist mental health and employment support services that can effectively lead to inter-agency referrals, collaboration and knowledge transfer across sectors.

8.2.3 Integrating mental health and employment services

The Committee determined that establishing local area networks, including representation from employment services, AMHS, and PDRSS, may be a useful approach in promoting knowledge sharing and inter-agency collaboration and referral.

The Committee also identified benefits in developing integrated service delivery models. Integrated service delivery models involve locating employment specialists within mental health services teams. There was strong support among Inquiry participants for this approach.

There was a view among some Inquiry participants that locating employment specialists within mental health services can be a particularly effective approach in achieving coordination. In their submission, Pathways & Barwon Health expressed the view that:

Integrated services that draw on the specialisations of all associated stakeholders consistently prove to be the most effective models in assisting people with mental illness gain and retain rewarding employment ... these integrated services also promise greater efficiency than segregated services, as shared clients, shared decision making, and coordinated care effectively and positively improves the level of workforce participation and social inclusion of people living with a mental illness.⁵⁴

In particular, Inquiry participants advocated locating employment specialists within community mental health service teams to deliver vocational support to mental health consumers using Individual Placement and Support (IPS) principles.⁵⁵ Box 8.3 describes the core principles and evidence base for IPS.

⁵⁴ *Submission 23*, Pathways Rehabilitation and Support Services & Barwon Health, pp.10-11.

⁵⁵ *Submission 42*, Dr Geoff Waghorn—Queensland Centre for Mental Health Research, p.11.

Box 8.3 Individual Placement and Support (IPS)

IPS is a model of job search assistance for people with low prevalence mental illness, particularly schizophrenia. It was developed by researchers at the Dartmouth Psychiatric Research Centre in the United States. Seven key principles inform IPS:

- the goal is competitive employment in the open labour market
- consumer choice as the only entry criterion
- rapid commencement of job search activity within four weeks of commencement
- integration of mental health care with vocational services
- assistance components are determined by consumer preferences
- support is not time-limited
- benefits counselling to minimise disincentives through the impact on health benefits, income support payments and fringe benefits.⁵⁶

The Committee heard that there is a strong evidence base for IPS. Dr Geoff Waghorn explained that when all principles are closely adhered to, IPS 'is typically 2–3 times more effective than the best alternative forms of supported employment or vocational rehabilitation.'⁵⁷ This view was echoed by Ms Joyce Goh, Executive Officer of the former Victorian Mental Health Reform Council.⁵⁸ For example:

- In randomised controlled trials across 11 sites in the United States, 61 per cent of participants who received job search assistance through IPS found competitive employment within 12 months compared to just 23 per cent of those who received job search assistance through other programs. IPS participants also typically obtained jobs nearly 10 weeks earlier than those in other programs.⁵⁹
- Trials of IPS across six European countries have found that twice as many IPS participants gained competitive jobs as clients of traditional vocational rehabilitation services (55 per cent compared with 28 per cent). They also 'sustained jobs longer and earned more than those who were supported by the best local vocational rehabilitation alternatives.'⁶⁰
- As outlined in Chapter 4, there is emerging evidence that IPS can assist people with mental illness to achieve educational goals also as part of their recovery. However, far fewer trials have been carried out of IPS as an approach to supporting people with mental illness in returning to study or vocational training.

Source: Compiled by Family and Community Development Committee.

The Committee identified two broad approaches to integrating treatment and vocational support based on IPS principles:

- locating employment consultants within mental health services to directly provide job search assistance to people who use mental health services
- employing occupational therapists within mental health service teams to promote the benefits of employment to clinicians and consumers, facilitate referral to external employment services, and support inter-agency case coordination.

56 King, R., Waghorn, G., Llyod, C. et al. (2006) 'Enhancing employment services for people with severe mental illness: The challenge of the Australian service environment'. *Australian and New Zealand Journal of Psychiatry*, Vol. 40, pp.471-77, p.474; Killackey, E., Jackson, H.J., & McGorry, P.D. (2008) 'Vocational intervention in first-episode psychosis: Individual placement and support v. treatment as usual'. *The British Journal of Psychiatry*, Vol. 193, pp.114-20, p.115.

57 *Submission 42*, Dr Geoff Waghorn—Queensland Centre for Mental Health Research, p.8.

58 *Transcript of evidence 4*, Victorian Mental Health Reform Council, 7 November 2011, p.7.

59 Bond, G.R., Drake, R.E., & Becker, D.R. (2008) 'An update on randomised controlled trails of evidence-based supported employment'. *Psychiatric Rehabilitation Journal*, Vol. 31, pp.280-90.

60 Sainsbury Centre for Mental Health *Doing what works: Individual placement and support into employment*. London, Sainsbury Centre for Mental Health, p.4.

Table 8.1 describes how these different approaches have been trialled in Australia.

Table 8.1: Australian trials of Individual Placement and Support (IPS)

Trial	Details
Orygen Youth Health (OYH)	<ul style="list-style-type: none"> • In 2005-06, OYH carried out the first randomised control trial of IPS among young people with first episode psychosis. • 41 clients of OYH's Early Psychosis Prevention and Intervention Centre (EPPIC) took part in a six-month trial. • An employment consultant located with OYH assisted 20 clients to find work, while the remaining participants were referred to local employment services. Support provided by the employment consultant included: help with the preparation of resumes, intensive job searching, canvassing employers on behalf of clients, attending Centrelink appointments with clients, work-site visits following placement, and assistance managing disclosure. • The IPS group had significantly better employment outcomes than those referred to external employment agencies: <ul style="list-style-type: none"> • 13 out of 20 people in the IPS group entered a job compared to 2 out of 21 in the control group • The average number of weeks worked by IPS participants was five weeks, compared with no weeks among those in the control group • The proportion of IPS participants receiving income support fell from 80 per cent to 55 per cent, with no change among those in the control group.⁶¹ • OYH has recently completed a much larger trial of IPS among 146 EPPIC clients. This trial has broadly confirmed the results of the first study, while a follow-up study has also found 'that two-thirds of the people who got a job are still employed at 18 months.'⁶²
Queensland Trial	<ul style="list-style-type: none"> • The Queensland Centre for Mental Health Research has recently evaluated a three-year multi-site trial of IPS in Queensland. • The trial finished in 2010 and involved locating an employment specialist in 12 public mental health services. • The trial results have yet to be formally published. However, Dr Waghorn told the Committee that the results show that '56.7 per cent of clients of the integrated service commenced employment, whereas only 33 per cent of clients commenced employment among those referred by the mental health team to the best available local DES services.'⁶³

Trial	Details
Hunter New England Area Health Service	<ul style="list-style-type: none"> • Between 2006 and 2008, two occupational therapists were employed as Vocational Education, Training and Employment (VETE) consultants within an early psychosis rehabilitation team.⁶⁴ • VETE consultants had expertise in vocational rehabilitation and were employed to work alongside clinicians providing primary care coordination to promote the benefits of employment for people recovering from mental illness and to educate staff about evidence-based practices in vocational rehabilitation.⁶⁵ • VETE consultants established formal links with three separate employment services to provide flexibility in matching consumers to appropriate programs. • Memoranda of understanding were signed to establish formal procedures for maintaining collaboration and sustained communication between services, including: regular client reviews, joint appointments, and sharing of assessment and relapse prevention information.⁶⁶ • Provided external employment agencies adhered to IPS principles, the trial achieved similar outcomes to IPS trials in which job search assistance was directly provided through mental health services.⁶⁷ <ul style="list-style-type: none"> • 33 out of the 43 participants (76.7 per cent) managed to obtain employment • More than 60 per cent of those who gained employment were still working at the end of the evaluation.⁶⁸

Source: Compiled by Family and Community Development Committee.

FINDING 7

That trials reveal locating employment specialists within mental health services using Individual Placement and Support (IPS) principles is the most effective model of vocational support for people with mental illness.

The benefits of integrating services

The Committee identified that locating employment specialists within mental health service teams has several benefits. In a recent study on the implications of IPS for clinical services, Lloyd suggests that:

Having the employment specialist as part of the mental health team ensures that vocational goals are a high priority ... Having the employment specialist discuss

61 Killackey, Jackson, & McGorry (2008) 'Vocational intervention in first-episode psychosis: Individual placement and support v. treatment as usual', pp.117-18.

62 *Transcript of evidence 13*, Orygen Youth Health, 28 February 2012, p.6.

63 *Submission 42*, Dr Geoff Waghorn—Queensland Centre for Mental Health Research, p.11.

64 Sherring, J., Robson, E., Morris, A. et al. (2010) 'A working reality: Evaluating enhanced intersectoral links in supported employment for people with psychiatric disabilities'. *Australian Occupational Therapy Journal*, Vol. 57, No. 4, pp.261-67, p.262.

65 Frost, B., Morris, A., Sherring, J. et al. (2008) *Vocational education, training and employment (VETE) pilot project report: Psychiatric rehabilitation service 2006-07*. North Sydney, NSW Health, p.7.

66 Frost, Morris, Sherring et al. (2008) *Vocational education, training and employment (VETE) pilot project report: Psychiatric rehabilitation service 2006-07*, p.15.

67 Frost, Morris, Sherring et al. (2008) *Vocational education, training and employment (VETE) pilot project report: Psychiatric rehabilitation service 2006-07*, p.15.

68 Sherring, Robson, Morris et al. (2010) 'A working reality: Evaluating enhanced intersectoral links in supported employment for people with psychiatric disabilities', pp.264-65.

employment issues routinely should increase overall acceptance and integration within the clinical team.⁶⁹

Delivery of vocational support and mental health services from a single site also reduces barriers to mental health consumers accessing employment services, including:

- difficulties experienced by people with mental illness having to navigate separate service systems
- practical barriers such as travel between sites and the duplication of assessment processes.⁷⁰

Researchers also argue that co-location can facilitate more seamless coordination and collaboration across services. This is because geographical proximity creates opportunities for formal and informal communication between mental health practitioners and employment specialists.⁷¹ By contrast, when services are externally located, maintaining communication to ensure that treatment and vocational rehabilitation plans are aligned requires increased time and effort.⁷² As Dr Waghorn identified in his submission:

Once a formal partnership is established that co-locates an employment specialist into a mental health team, case management, clinical, and other community services can be coordinated with the vocational plan. This is rarely possible when the services remain segregated, and inevitably the treatment goals get out of phase with the vocational goals.⁷³

FINDING 8

That engaging employment specialists within mental health services reduces barriers experienced by people with mental illness accessing vocational support. For example, the difficulties in navigating separate service systems and undergoing lengthy referral and assessment processes.

Locating employment consultants within early intervention services

In co-locating employment specialists within mental health teams, the Committee determined that targeting early intervention and youth-focused mental health services may deliver the greatest benefit. These include Early Psychosis Prevention and Intervention Centres (EPPIC) and headspace sites, as well as Child and Adolescent Mental Health Services (CAMHS). As Killackey, Jackson, and McGorry highlight in relation to providing vocational support during the early stages of psychosis:

Vocational intervention at this time has tremendous potential not only to provide short-term employment experience and skills, but also to prevent development of long-term unemployment and its associated personal, economic and health costs.⁷⁴

69 Lloyd, C. & King, R. (2012) 'Implementation of supported employment: What are the implications for clinical services?'. *Journal of Rehabilitation*, Vol. 78, No. 1, pp.25-29.

70 Sainsbury Centre for Mental Health *Doing what works: Individual placement and support into employment*, p.5.

71 King, Waghorn, Llyod et al. (2006) 'Enhancing employment services for people with severe mental illness: The challenge of the Australian service environment', p.476.

72 King, Waghorn, Llyod et al. (2006) 'Enhancing employment services for people with severe mental illness: The challenge of the Australian service environment', p.476.

73 *Submission 42*, Dr Geoff Waghorn—Queensland Centre for Mental Health Research, p.7.

74 Killackey, Jackson, & McGorry (2008) 'Vocational intervention in first-episode psychosis: Individual placement and support v. treatment as usual', p.119.

They highlight that ‘unemployment is a risk factor for the development or exacerbation of mental illness.’⁷⁵ Early vocational support can therefore assist in preventing deterioration in symptoms among people experiencing the early onset of mental illness. Another advantage of intervention at this stage is that:

Often those with illness are not yet accessing welfare benefits, which have been shown to pose a substantial barrier to participation in the workforce.⁷⁶

FINDING 9

That locating employment specialists within early intervention and youth-focused services increases the potential to prevent long-term unemployment and its associated personal, economic and health costs.

The Committee recognises that some early intervention mental health services in the state already provide integrated mental health treatment and vocational support. For example, OYH’s existing EPPIC service incorporates vocational support alongside clinical support, as do many headspace centres. However, in its submission, OYH identified that ‘currently most Victorian young people with mental ill-health do not have effective access to headspace and EPPIC.’⁷⁷ The Committee determined that there is a pressing need to prioritise increased access to these services.

The Victorian Government has recently committed to expanding the provision of youth-focused and early intervention services. In January 2012, the Victorian Government submitted a proposal to the Commonwealth Government to jointly fund the establishment of five new and one expanded EPPIC service for young people aged 15–24 across the state. These new EPPIC services would enable an additional 1,200 young people with early psychosis to be treated each year.⁷⁸ Four additional headspace sites are also being established in Dandenong, Knox, Shepparton and Ballarat with co-funding from the Victorian and Commonwealth Governments.⁷⁹ Further headspace centres are also planned for Kew, Werribee and Craigieburn/Seymour by 2015.⁸⁰

The Committee welcomes the establishment of these services, which provide an opportunity for the Victorian Government, in partnership with the Commonwealth Government, to increase access to evidence-based integrated service delivery models. The Committee recommends that these new services follow the example of the existing EPPIC service and several headspace sites in employing an employment specialist within the service to deliver vocational support alongside clinical care.

75 Killackey, Jackson, & McGorry (2008) ‘Vocational intervention in first-episode psychosis: Individual placement and support v. treatment as usual’, p.119.

76 Killackey, Jackson, & McGorry (2008) ‘Vocational intervention in first-episode psychosis: Individual placement and support v. treatment as usual’, p.119.

77 *Submission 18*, Orygen Youth Health, p.9.

78 The Hon Mary Woolridge MP, State Government of Victoria, *EPPIC bid for more youth mental health services*, Media release, 16 January 2012.

79 The Hon Mary Woolridge MP, State Government of Victoria, *New headspace sites to enhance access to youth mental health*, Media release, 25 October 2011. See also Know Leader (2012) *Knox confirmed for new headspace centre*. Accessed on 13 September from <http://knox-leader.whereilive.com.au/news/story/knox-confirmed-for-new-headspace-site/>.

80 Headspace (2012). *Headspace welcomes announcement of next 15 centres*. Accessed on 13 September from <http://www.headspace.org.au/about-headspace/media-centre/media-releases/headspace-welcomes-announcement-of-next-15-centre-locations>.

→ RECOMMENDATION 8.5:

That the Victorian Government works with the Commonwealth Government to integrate vocational support within early intervention focused mental health services, including Early Psychosis Prevention and Intervention Centres (EPPIC) and headspace.

Challenges in integrating services

The Committee recognises that there are funding challenges in integrating vocational support with specialist mental health services, particularly when employment specialists are staff of employment support services that are funded by the Commonwealth. Locating employment specialists within clinical service teams may imply increased costs for employment support service providers due to the lower caseloads required to deliver IPS.⁸¹ The client funding that employment service providers receive from DEEWR to deliver job search assistance and support may not be enough to meet the costs of providing IPS.

King et al. suggest that the potential for integrated services to result in decreased demand for clinical services may offset any increased costs associated with delivering IPS compared to standard approaches to vocational support.⁸² However, these savings will mainly be realised by state governments rather than the Commonwealth. Also, few IPS trials have included a comprehensive analysis of the costs and benefits of locating employment specialists within mental health services.⁸³

As discussed in Chapter 3, the Victorian Government has announced funding to trial the co-location of four education and employment officers in two selected AMHS. As part of this trial, the Committee encourages the Victorian Government to consider issues related to the cost-effectiveness of integrating mental health and employment services, including:

- whether the cost of locating employment specialists within mental health services can be met through existing Commonwealth-funding of employment support services
- whether costs savings from reduced demand for clinical and other state-funded services support a case for the State government to fund the location of employment specialists within mental health services.

→ RECOMMENDATION 8.6:

That in trialling the co-location of education and employment officers in Area Mental Health Services, the Victorian Government evaluates cost-barriers to integrating vocational support with clinical care, and strategies to address these challenges.

81 For example, Orygen Youth Health suggests that employment consultant caseloads should not be higher than 25 clients. *Submission 18*, Orygen Youth Health, p.10.

82 King, Waghorn, Llyod et al. (2006) 'Enhancing employment services for people with severe mental illness: The challenge of the Australian service environment', p.476.

83 Sainsbury Centre for Mental Health (2009) *Briefing 41: Commissioning what works—The economic and financial case for supported employment*. London, Sainsbury Centre for Mental Health, p.4.

Appendix 1: Submission guide

INQUIRY INTO WORKFORCE PARTICIPATION BY PEOPLE WITH MENTAL ILLNESS

SUBMISSION GUIDE

TERMS OF REFERENCE

The Family and Community Development Committee has been asked by the Legislative Assembly to inquire into workforce participation by people with mental illness. The Committee is asked to consider:

- a) evidence of the low rate of workforce participation of people with mental illness, and the social and economic costs involved;
- b) identification of the barriers that people with mental illness experience in gaining and retaining employment;
- c) the respective roles of, and collaboration between, local, state and Commonwealth governments, business and community organisations in supporting the workforce participation of people with mental illness;
- d) the effectiveness of programs that aim to improve the workforce participation of people with mental illness, including best practice models;
- e) opportunities for tailoring education and vocational training for the needs of people with mental illness;
- f) effective measures to support employers to recruit, employ and retain people with mental illness;
- g) the role of mental health services, and general health and community services in improving the workforce participation of people with mental illness.

This Guide is intended to assist organisations and individuals who wish to make a written submission and/or who would like to present evidence before the Committee at a public hearing. The questions in this Guide provide an indication of the issues the Committee will be considering as part of this Inquiry, but they are not intended to be exhaustive and it is not necessary to answer all the questions in comments or submissions.

SCOPE OF INQUIRY

In undertaking its Inquiry, the Committee will focus strongly on the Victorian context relating to workforce participation by people with mental illness.

While focusing specifically on Victoria, the Committee recognises the overlaps in issues across Commonwealth and State Government roles in mental health and workforce participation.

The Committee has considered the Parliament of Australia's current Inquiry into Mental Health and Workforce Participation being undertaken by the House of Representatives Standing Committee on Education and Employment.

To ensure maximum value and to minimise duplication, the two Committees are in communication regarding overlaps across Victorian and Commonwealth issues.

In addition to these discussions, since forming in May 2011, the Committee has been briefed by the Victorian Government on issues relating to mental illness and workforce participation.

Within its terms of reference, the Family & Community Development Committee aims to focus its Inquiry on state-based issues relating to

- opportunities for tailoring education and training programs – including issues relating to early intervention in schools;
- the effectiveness of Victorian programs that aim to assist participation in the workforce;
- the role of business and methods of supporting employers in the Victorian context and government interventions in recruitment and retention – including OHS issues, healthy workplaces and mental health; and
- the role of mental health services in improving workforce participation of people with mental illness.

DEFINING WORKFORCE PARTICIPATION AND MENTAL ILLNESS

The Committee recognises that understanding the nature of workforce participation by people with mental illness can vary depending on interpretations of 'workforce participation' and 'mental illness'.

The Australian Human Rights Commission notes that 'mental illness is more prevalent than many people realise. Around 45% of Australians aged between 16 and 85 will experience a mental illness at some point in their life'.¹

'Mental illness'

- includes a range of emotional, psychological and psychiatric conditions that fall within a spectrum of diagnoses from high prevalence (eg stress, anxiety, depression) to low prevalence (eg schizophrenia, bi-polar) disorders.
- can be episodic and have varying impacts on a person's capacity to function at different times.
- can develop in the workplace – an unhealthy work environment or a workplace incident can cause considerable stress and exacerbate or contribute to, the development of a mental illness.²

'Workforce participation'

- relates to the active involvement of people in the labour market. The participation rate is the proportion of the population aged 15 to 64 years who are working or who are willing and able to look for work (active jobseekers).
- is influenced by complex and interrelated factors in the economy and the community, including taxation, the social security system, superannuation and retirement policies, workplace relations, education and training, availability of childcare, people's health and wellbeing, workplace culture, occupational health and safety, hiring and recruitment policies and procedures, and employer attitudes.
- can be promoted through 'supported employment', which involves group-based assistance provided by business services or social enterprises offering supported work in modified work settings.

Q What are the key features of mental illness that need to be understood in the context of workforce participation?

PARTICIPATION IN THE WORKFORCE BY PEOPLE WITH MENTAL ILLNESS

High rates of workforce participation are socially and economically beneficial for the general population, including people with mental illness.

The Committee recognises, however, that employment rates for people with mental illness are still well below that of people with no mental illness. The OECD has identified internationally that those reporting a mental health condition or disability have the lowest labour market participation of all.

Data relating to the experience of people with mental illness in the workforce is minimal. In 2006, Boston Consulting Group analysed 1998 data and identified non-participation rates for Victorians with mental illness.

- 72% non-participation by people with schizophrenia
- 54% non-participation by people with moderate levels of psychiatric disability.³

According to the Australian Bureau of Statistics (ABS), people with mental illness in Australia experience higher rates of unemployment and lower rates of labour force participation than those with physical disability.

- In 2003, the workforce participation rate for people with mental illness in Australia was 29%. This is low in comparison to the rate for physical disability (49%) and the general community (74%).

Evidence also suggests that in recent years their relative employment prospects have declined.⁴

The Committee recognises that people with mental illness experience employment restrictions. These can include the need for a support person, difficulty changing jobs, and restrictions in the number of hours worked. These restrictions

¹ Australian Human Rights Commission (2010) 2010 Workers with a Mental Illness: A Practical Guide for Managers.

² AHRC 2010 Workers with a Mental Illness: A Practical Guide for Managers,

³ Boston Consulting Group (2006) *Improving mental health outcomes in Victoria*, Report to the Government of Victoria.

⁴ ABS (1993, 1998 and 2003) *Survey of Disability, Ageing and Carers*, Australia (Cat No. 4430.0)

increase for people with severe mental illness or a high prevalence disorder.

Q What are the rates of participation by people with mental illness in the workforce and how do these rates differ for high and low prevalence mental illnesses?

Q What capacity do people with mental illness have to participate in the workforce?

Q To what extent do people with mental illness want to participate in the workforce?

year, of which 80% was due to mental illnesses such as depression and anxiety.

- This equated to about a \$660 million yearly loss to the Victorian economy.
- Preliminary research shows that Australian businesses lose over \$6.5 billion a year by failure to provide early intervention/treatment for employees with mental illness.⁶

Q What are the costs of low workforce participation rates by people with mental illness?

Q What practical strategies can be implemented to work towards minimising these costs?

COSTS OF LOW WORKFORCE PARTICIPATION

The Committee has been asked to consider the costs associated with low workforce participation rates for people with mental illness.

It notes that there are a range of social and economic costs that are experienced at individual, societal and economic levels.

At an individual level, there are a range of negative consequences relating to low participation in the workforce for people with mental illness. These can include:

- Isolation
- Substance use
- Financial difficulty
- Increased risk of hospitalisation and suicide⁵

The social costs are interlinked and can include isolation, homelessness, the diversion of resources in health and community care and the effect of mental illness on families.

The economic costs associated with low participation rates by people with mental illness relate to absenteeism, reduced and disrupted productivity and the costs of welfare and support. For example:

- The 2006 Boston Consulting Group report to the Victorian Government estimated that mental illness led to about 4.7 million absentee days a

BENEFITS OF WORKFORCE PARTICIPATION

The benefits of workforce participation for people with mental illness also occur at individual, societal and economic levels.

Research has identified that:

- At an individual level, work assists with structuring time and routine, social contact, collective effort and purpose, social identity and status, personal achievement, and regular activity and involvement.⁷
- At a social level, people who work are healthier and better connected to others – their work colleagues, their families, their neighbours and the community.
- Economically, increasing workforce participation by people with mental illness assists contributes to the supply of labour to meet the needs of business and industry.

The Mental Illness Fellowship Australia (MIFA) indicated that 60.1% of respondents to its *Australians Talk Mental Illness* survey identified employment and employment support as a key issue for people with mental illness. This was second only to housing and housing support (70.1%).

The Committee recognises that increased workforce participation by people with mental illness has the potential to reduce relapse rates and prevent acute inpatient stays, with benefits

⁵ Perkins R, Famer P, & Litchfield P (2009) *Realising ambitions: Better employment support for people with a mental health condition*, Department for Work and Pensions, London, UK.

⁶ MHCA (c2008) Mental Health Fact Sheet: Mental Health and Employment.

⁷ Waghorn G. & Lloyd C (2005) The employment of people with mental illness, *AeJAMH*, 4: 2, p.13.

for both people with mental illness and for the broader community.

Research has also demonstrated that many adults diagnosed with severe mental illness want to work in the mainstream labour market and that employment is often a key objective in recovery.⁸ Benefits of work in the context of mental health treatment include:

- Work as a restorative psychological process
- Work to improve self-concept
- The protective effect of work
- The social dimension of work.⁹

Q In what ways does workforce participation by people with mental illness provide benefits at an individual, societal and economic level?

BARRIERS TO WORKFORCE PARTICIPATION

The Committee will consider the barriers to workforce participation by people with mental illness in Victoria and will aim to identify the most effective enablers that support workforce participation.

It recognises that there are three broad components to the barriers and enablers that affect workforce participation by people with mental illness.

Individual:

- Challenges can include the impact of mental illness on the person wanting to participate in the workforce.
- Enablers can include effective support and treatment.

External:

- Challenges might include the nature of the labour market and the availability of suitable employment assistance
- Enablers can include the provision of effective support in the workplace.

⁸ Alverson R, et al (2006) An ethnographic study of job seeking amongst people with severe mental illness, *Psychiatric Rehabilitation Journal*, 30:1, p.15.

⁹ Waghorn G. & Lloyd C (2005) The employment of people with mental illness, *AeJAMH*, 4: 2, p.12.

Systemic:

- Challenges include stigma, discrimination and low expectations of some carers and health professionals.
- Enablers can include education, awareness raising and legislative intervention.

The Committee acknowledges that these represent only some of the challenges and barriers experienced by people with mental illness seeking to participate in the workforce.

Victorians with mental illness are a highly diverse group, with varying backgrounds, capacities, needs and desires.

The Committee is seeking perspectives regarding the most effective enablers to support workforce participation by people with mental illness.

Q What are the barriers experienced by people with mental illness seeking to participate in the workforce?

Q How can workforce participation by people with mental illness be most effectively enabled?

ROLE OF GOVERNMENT IN SUPPORTING WORKFORCE PARTICIPATION BY PEOPLE WITH MENTAL ILLNESS

The Committee's Terms of Reference include the need to consider the role of government in workforce participation by people with mental illness.

Many of the incentives or disincentives to work can be influenced by government, particularly the Commonwealth and States. In some areas, such as education and training and childcare, both governments are key players.

The Australian Government has responsibility for employment programs, income support and other benefits. The Commonwealth Government also controls economic determinants through taxation, superannuation, welfare and labour policy.

- The 2009 *National Mental Health & Disability Employment Strategy* (NMHDES) is a major policy framework informing directions relating to mental health and workforce participation.

The Victorian Government has involvement in policy, funding and delivery of health and community services used by Victorians with mental illness. These include PDRSS, area mental health services and some training and workforce programs. It is pursuing the following initiatives:

- The Victorian mental health reform strategy – *Because Mental Health Matters* – has specified a goal 'to support the participation of people with mental health problems in the workforce'
- *Pathways to Economic Participation* initiative – including a new program to support people with a severe mental illness to access employment and education and training opportunities

Local Governments can provide information and inclusion pathways for Victorians with mental illness.

The Committee will be considering the intersection of Commonwealth, state and local government service provision and government roles in supporting workforce participation by people with mental illness.

Q In what ways do the roles of Commonwealth, State and Local Government intersect in the context of workforce participation by people with mental illness? How effective is cross-government collaboration?

Q Is there a stronger role for local government in promoting the workforce participation of people with mental illness? What would this look like?

Q What whole of government approaches need to be considered in enabling workforce participation by people with mental illness?

ROLE OF EMPLOYERS, INDUSTRY AND UNIONS IN SUPPORTING PEOPLE WITH MENTAL ILLNESS IN THE WORKPLACE

The Committee will consider the role of business in supporting workforce participation by people with mental illness. Employers and business have a key influence on workforce participation, including recruitment, retention and workplace practices.

Unions also have an important role, and influence workplace practices such as health and safety, flexibility and diversity.

The Committee is interested in strategies for achieving healthy workplaces and the practices that contribute to supportive workforce cultures in the context of mental health.

The Australian Human Rights Commission has noted that

It is often presumed that a worker's mental illness develops outside the workplace. However, an 'unhealthy' work environment or a workplace incident can cause considerable stress and exacerbate, or contribute to, the development of mental illness.¹⁰

Q In what ways do workplace practices influence participation in employment by people with mental illness?

Q How can business effectively support people with mental illness in the workplace?

Q What role do unions have in the context of mental illness and workforce participation?

ROLE OF COMMUNITY IN SUPPORTING PEOPLE WITH MENTAL ILLNESS IN THE WORKPLACE

The Committee acknowledges that there are also many ways in which communities are involved in supporting people with mental illness to participate in the workforce.

This support can include people caring for a family member with mental illness and friends or work colleagues supporting the workforce participation of someone with mental illness. Peer support is also a significant way that people with mental illness can be supported in workforce participation.

The Committee is interested to hear about the ways in which these groups can be supported to enable people with mental illness to participate in the workforce.

¹⁰ AHRC, 2010 *Workers with a Mental Illness: A Practical Guide for Managers*.

Q How can carers, friends and colleagues be assisted in their role in supporting people with mental illness in workforce participation?

Q What role can peer support provide in the workforce participation of people with mental illness?

Q Into the future, what role should specialist mental health services assume in supporting workforce participation by people with mental illness?

Q Do other health and community services have a role in supporting workforce participation by people with mental illness? What should this look like?

ROLE OF HEALTH AND COMMUNITY SERVICES IN SUPPORTING WORKFORCE PARTICIPATION BY PEOPLE WITH MENTAL ILLNESS

The Terms of Reference ask the Committee to consider the role of health and community services in supporting workforce participation by people with mental illness, with a specific emphasis on mental health services.

The role of health and community services in Victoria has primarily been to provide tertiary end intervention for people with mental illness. In recent times, shifts towards prevention and early intervention have seen a broader role for mental health services.

The stronger focus on prevention and early intervention in Victoria aims to intervene early in life, illness and episode. A related objective is to increase mental health literacy across all population groups.

Within this broader context of prevention and early intervention, specialist mental health services have increasingly been involved in areas that reduce the severity of illness and assist in recovery.¹¹

The Committee recognises, therefore, that mental health services have been engaging in the provision of services that assist people with mental illness to participate in the workforce.

The Committee is interested to hear views regarding this changing role of specialist mental health services in supporting workforce participation by people with mental illness.

EFFECTIVENESS OF PROGRAMS SUPPORTING WORKFORCE PARTICIPATION BY PEOPLE WITH MENTAL ILLNESS

The Committee's Terms of Reference ask it to consider the effectiveness of programs that aim to support people with mental illness participate in the workforce. In this context, the Committee is particularly interested in Victorian and state based programs.

Programs have been established that relate to employment specifically and others that focus on education and training. Some programs combine education and employment.

According to Waghorn & Lloyd, employment programs tend to fall within one of the following categories:

- Specialised supported employment (previously known as Individual Placement and Support – IPS – approach) – the integration of employment and health services together through co-location.
- Transitional employment – continuous availability of intensive on-site support developed specifically for people with psychiatric disability.
- Specialised vocational rehabilitation – multi-disciplinary teams that provide a form of coordinated mental health care and vocational services.¹²

The nature of mental illness often means that education is disrupted due to the way an illness emerges or recurs over the life-course. Given the importance of education to career development, workforce participation can be affected by education outcomes.

¹¹ Victorian Government (2009) *Because Mental Health Matters*, Department of Health, Victoria.

¹² Waghorn G. & Lloyd C (2005) The employment of people with mental illness, *AeJAMH*, 4: 2.

The Committee is interested to hear about education programs and early intervention in schools that can assist people with mental illness and improve workforce participation.

It is also seeking views on the value of training in supporting workforce participation – both workplace training and prevocational training.

Q What types of employment programs are most beneficial in supporting workforce participation by people with mental illness?

Q What education and training programs are most effective in the career development of people with mental illness?

Q What role should mental health services assume in employment, education and training programs?

LOOKING TO THE FUTURE

As noted, the Committee has determined that the scope of the Inquiry needs to be specifically focused on how interventions in Victoria can improve opportunities for participation in the workforce by people with mental illness.

To this effect, the Committee is keen to hear of innovative and evidence-based approaches to enabling those Victorians with mental illness seeking opportunities for workforce participation to secure and retain suitable employment.

Q What are the top 3 priorities for achieving improved outcomes for people with mental illness seeking to participate in the workforce?

SUBMISSIONS

The Committee welcomes written submissions addressing one, multiple or all Terms of Reference of the Inquiry.

Submissions close on **11 November 2011**.

Guidance regarding submissions can be found at: www.parliament.vic.gov.au/committees/submissions.html

Submissions can be provided in either hard copy or by email to the Executive Officer.

Email: janine.bush@parliament.vic.gov.au

Hard copy submissions should be sent to:

The Executive Officer
Family and Community Development Committee
Parliament House
Spring Street
EAST MELBOURNE VIC 3002

The Committee draws your attention that **all submissions are public documents unless confidentiality is requested**.

Please contact the Committee if confidentiality is sought, as this has bearing on how evidence can be used in the report to Parliament.

Appendix 2

List of submissions

1	Mr Philip Endersbee, Executive Chairman, Wilderness Wear Australia
3	Ms Jennifer Marriner
4	Name withheld
6	Mr Vikein Mouradian
7	SANE Australia
8	Geelong and Region Trades Hall and Labour Council
9	Mr Peter Newton
10	Ms Brenda Spreadbury
11	Office of the Public Advocate (OPA)
13	Name withheld
14	The Royal Australian and New Zealand College of Psychiatrists (Victoria Branch)
15	Prahran Mission UnitingCare
16	Open Minds
17	Ethnic Communities' Council of Victoria (ECCV)
18	Orygen Youth Health Research Centre
19	<i>beyondblue</i>
20	Kardinia Mental Health Services, Salvation Army Geelong
21	Mr Pete Dowe
22	Recruitment and Consulting Services Association (RCSA)
23	Professor Tom Callaly, Executive Director & Clinical Director, Mental Health, Drug & Alcohol Services, Barwon Health Mr Mark Rosser, Program Development Manager, Pathways Rehabilitation and Support Services
24	Australian Human Resources Institute (AHRI)
25	Mr John Gascoigne
26	Victorian Mental Health Carers Network
27	Bendigo Community Health Services
28	VincentCare Victoria
29	Mission Australia
30	Forensicare (Victorian Institute of Forensic Mental Health)
31	National Centre for Vocational Education Research (NCVER)

32	Mental Health Community Advisory Group, Peninsula Health Mental Health
33	Associate Professor Jennifer Martin, Social Work, RMIT University
34	Australian Medical Association (AMA Victoria)
35	Australian Network on Disability (AND)
36	Lantern
37	Psychosocial Research Centre
38	Mental Health and Employment Working Group, Barwon South Western (BSW) Region Community Mental Health Planning and Service Coordination Initiative
39	Jesuit Social Services
40	Mental Health Legal Centre
41	Victorian Equal Opportunity and Human Rights Commission (VEOHRC)
42	Dr Geoff Waghorn
43	Social Firms Australia (SoFA)
44	JobWatch

Appendix 3

Public hearings

The Committee held the following Public Hearings around the State:

Date	Venue
4 November 2011	Geelong
7 November 2011	Melbourne
18 November 2011	Bendigo
21 November 2011	Melbourne
24 February 2012	Melbourne
7 March 2012	Melbourne
21 March 2012	Melbourne
30 April 2012	Melbourne

4 November 2011, Geelong

Barwon Health; and Pathways Rehabilitation and Support Services	
Dr Tom Callaly	Executive Director and Clinical Director, Mental Health, Drug and alcohol Services, Barwon Health
Mr Mark Rosser	Program Development Manager, Pathways Rehabilitation and Support Services
Grow, Geelong	
Mr Robert Turnour	Regional Manager
Ms Karen Milne	Group Member
Ms Natalie Smith	Group Member
Geelong and Region Trades Hall and Labour Council; and Australian Services Union	
Ms Christine Couzens	President, Geelong and Region Trades Hall and Labour Council
Ms Lisa Darmanin	Assistant Branch Secretary, Australian Services Union

7 November 2011, Melbourne

Victorian Mental Health Reform Council	
Mr Terry Laidler	Chair
Ms Joyce Goh	Executive Officer
Mental Health Carers' Network	
Mr Colin Fryer	Chairman
Ms De Backman-Hoyle	Member and Carer

Eastern Region Mental Health Association; and Psychiatric Disability Services of Victoria (VICSERV)

Ms Anthea Tsismetsi	Policy and Research Officer, Psychiatric Disability Services of Victoria (VICSERV)
Mr Peter Waters	Chief Executive Officer, Eastern Region Mental Health Association

18 November 2011, Bendigo
Youth Support and Advocacy Service

Mr Paul Bird	Chief Executive Officer
Ms Kerry Donaldson	Manager, Bendigo

21 November 2011, Melbourne
VPS Open Minds

Ms Maria Katsonis	Co-Convenor
Ms Sally Gibson	Co-Convenor

Australian Human Resources Institute

Mr Serge Sardo	Chief Executive Officer
Mr Paul Begley	National Manager, Government and Media Relations

Victorian Equal Opportunity and Human Rights Commission

Ms Karen Toohey	Acting Commissioner
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24 February 2012, Melbourne
St Vincent's Hospital Melbourne

Professor David Castle	Chair of Psychiatry
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Eastern Access Community Health

Mr Wayne Allen	General Manager, Employment and Social Enterprise
Ms Sarah Cromie	Regional Manager, Employment Services

Orygen Youth Health Research Centre

Professor Eoin Killackey	Head, Psychosocial Research Unit
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Brotherhood of St Laurence

Mr Michael Horn	Senior Manager, Research and Policy
Dr Dina Bowman	Principal Researcher, Research and Policy Centre

Social Firms Australia

Ms Caroline Crosse	Executive Director
Ms Dea Morgain	Manager, Workplace Supports Team
Mr Jeff Galvin	Peer Educator, SoFA HOPE Program

WISE Employment

Mr John Bateup	Chief Executive Officer
Mr Rick Kane	Policy Adviser
Mr David Christian	Community Investment Manager

Psychosocial Research Centre, University of Melbourne

Associate Professor Carol Harvey	Director
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7 March 2012, Melbourne**Davidson Trahaire Corpsych**

Ms Leonie Nowland	Clinical Services Director
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Mental Health at Work

Mr Bernard McNair	Director
Ms Ingrid Ozols	Managing Director

Recruitment and Consulting Services Association

Mr Steve Granland	Chief Executive Officer
Mr Simon Schweigert	Project Manager

Social Traders

Mr David Brookes	Managing Director
Mr Mark Daniels	Learning and Development Manager

Social Ventures Australia

Mr Kevin Robbie	Executive Director and Team Leader, Employment
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Transport Accident Commission

Ms Janet Dore	Chief Executive Officer
Ms Claire Amies	Head, Health Services Group

VicHealth Centre for the Promotion of Mental Health and Community Wellbeing (McCaughy Centre)

Associate Professor Anthony LaMontagne	Principal Research Fellow
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Mental Illness Fellowship of Victoria

Ms Laura Collister	General Manager, Rehabilitation Services
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21 March 2012, Melbourne

Centre for Youth Mental Health	
Professor Anthony Jorm	Professorial Fellow
Dr Nicola Reavley	Research Fellow, Mental Health Literacy Program
JobWatch	
Ms Zana Bytheway	Executive Director
WorkSafe Victoria	
Mr Greg Tweedly	Former Chief Executive Officer

30 April 2012, Melbourne

Department of Education and Early Childhood Development	
Ms Kris Arcaro	Director, Student Wellbeing and Engagement Division, School Education Group
Mr Andrew Abbott	Executive Director, Pathways, Participation and Youth Division, Higher Education and Skills Group

Appendix 4

Workplace mental health literacy training programs

During the Inquiry, the Committee identified several mental health literacy training programs being delivered within workplaces in Victoria. These are described below.

Beyondblue's National workplace program

Beyondblue's National workplace program is aimed at organisations seeking to be better informed and equipped at effectively managing depression in the workplace. Structured training is provided to senior executives, managers and general staff on depression and related mental illnesses through five workshops:

- A senior executive briefing on the importance of mental health in the workplace that incorporates the business case for tackling the most common mental health problems and leadership strategies to address mental health in the workplace.
- An organisation awareness workshop designed to increase awareness among staff members at all levels about depression and anxiety disorders, their impact and support for mental wellbeing.
- An interactive workshop specifically for employees (excluding managers, supervisors and team leaders) on common mental health problems, their impact on the workplace, and how to engage a colleague who may be experiencing a common mental health problem.
- A targeted workshop for managers on managing employees with depression, anxiety and other common mental health problems and developing strategies to manage mental health in the workplace.
- A targeted workshop for HR professionals that provides an overview of common mental health problems in the workplace, including an examination of organisational level prevention strategies, how to develop appropriate policies and procedures, and how to advise managers on addressing mental health problems with their staff.

Program workshops can be delivered directly by a *beyondblue* accredited trainer or staff members within organisations can be trained to deliver the program across organisations. Key learning objectives are then reinforced through the distribution of *beyondblue* information and reference materials.

A survey of more than 1,200 program participants from government and non-government organisations found that more than 80 per cent of program participants felt comfortable engaging a colleague struggling with depression after having completed the program. Before the program, only 64 per cent of participants said they felt comfortable approaching a colleague with depression to see 'what's wrong'. The evaluation also indicated that the program 'results in participants being

much more aware of helpful behaviours and more likely to identify responses which may be unhelpful, or even detrimental to recovery.¹

In March 2012, *beyondblue* also launched an eLearning *Workplace mental health awareness program*. This is a stand-alone resource that is freely available to workplaces and which can be incorporated into workplaces existing occupational health and safety or equal opportunity policy training programs. The aim of the resource is to inform workers about how to support someone with depression or anxiety in the workplace and about how to assist colleagues experiencing common mental health problems to get help.

SANE's Mindful Employer Program

A workplace mental health awareness training program that was developed in the UK in 2004. SANE has recently adapted this program for the Australian context and is now in the process of encouraging Australian businesses to commit to the program. SANE has partnered with the Australian Human Resources Institute to promote the program, although the Committee understands that the program is still in its very early stages.²

The *Mindful Employer* program consists of a number of components, including a *Mindful Employer* Charter that employers sign up to formalise their commitment to creating a better workplace for people affected by mental illness. SANE also provides consultancy services to workplaces as part of the program, as well as published resources that explain mental illness, its treatment, and ways to work with and support colleagues affected by mental illness.

The core component of the program is delivered as three eLearning modules. The first module provides an introduction to mental health issues and dispels some of the myths surrounding the impact of mental illness on workforce participation. The second module consists of a guide designed for general staff that helps workers to understand how to effectively work with, communicate with, and behave towards a colleague affected by mental illness. The final module is designed for those in management, HR, and supervisory roles and provides concrete information and advice on how to manage employees affected by a range of mental health problems. Fact sheets are also included on the rights and responsibilities of employers and employees under OHS, privacy and anti-discrimination legislation.

In addition to the eLearning modules, SANE also provides podcasts on mental health issues in the workplace as part of the program, as well as a confidential helpline that employers and employees can contact for advice and information. A customised online portal integrates the various components of the program and referral services can be provided to those who may need personalised one-on-one assistance.

1 *Beyondblue* (2007) *The beyondblue national depression in the workplace program*. Melbourne, *beyondblue*, Accessed on 18 September 2012 from http://www.beyondblue.org.au/index.aspx?link_id=59.1043&tmp=FileStream&fid=1005.

2 *Transcript of evidence to the House of Representatives Standing Committee on Education and Employment, Parliament of Australia, Inquiry into mental health and workforce participation*, Ms Barbara Hocking (Executive Director, SANE), Melbourne, 13 April 2011, p.23.

Mental Health @ Work

Mental Health @ Work works mainly with large private sector employers to develop and deliver tailored strategies and programs designed to build mentally healthy, resilient and supportive workplaces. This includes workshops and seminars delivered by qualified peer support workers, as well as eLearning tools and other resource material.

Programs are individually tailored to the requirements of each organisation, although they generally include:

- recognising the signs and symptoms of mental health problems in the workplace
- overcoming stigma
- portraying the lived experience of people with mental illness in the workforce
- what managers and co-workers can do to support people experiencing mental health problems
- the importance of work to wellbeing and supporting the return to work of employees with mental illness
- strategies for coping with and managing stress in the workplace.

Mental Health @ Work's programs are heavily framed within a preventative health approach that emphasises the savings to business that can be achieved—reduced absenteeism and increased on the job productivity—through fostering a mentally healthy and supportive work culture. Clients have included Telstra, National Australia Bank, Westpac, Coles, Origin Energy, Fairfax and ANZ.

The Committee understands that both Telstra and National Australia Bank have carried out evaluations of Mental Health @ Work's programs, concluding that the programs are evidenced-based and that there is a positive business case for implementing such programs.³ However, these evaluations have not been publicly released and Mental Health @ Work did not have permission to make them available to the Committee.

³ *Transcript of evidence 19, Mental Health @ Work, 7 March 2012, p.6.*

Appendix 5

Social firms and social enterprises employing workers with mental illness in Victoria

The Committee identified a range of social firms and enterprises in Victoria that provide employment opportunities to people with mental illness, either on a transitional or long-term basis. Table A.1 provides a snapshot of these social firms and enterprises to indicate their diversity in size and activity.

Table A.1: Social firms and enterprises employing workers with mental illness

Business	Industry	Sponsor organisation(s)	Additional information
MadCap cafés	Hospitality and catering	Eastern Regions Mental Health Association (ERMA) & Pathways Rehabilitation and Support Services)	<ul style="list-style-type: none"> Approximately 50 per cent of employees at any time have mental illness. Employment is provided on a transitional basis to provide jobseekers with mental illness with experience and skills to find jobs in the open labour market.
Clearwater Property Services	Property maintenance service	Pathways Rehabilitation and Support Services)	<ul style="list-style-type: none"> Funded as an Australian Disability Enterprise (ADE). Employs 70 workers with mental illness, mainly on a long-term basis.
The Mission Café Mission Caters Mission Shop	Hospitality and catering Retail	Prahran Mission	<ul style="list-style-type: none"> Approximately 25 per cent of employees have mental illness. Employment is provided in a supportive environment on a transitional basis.
Cleanforce	Property cleaning service	WISE Employment	<ul style="list-style-type: none"> Part funded as an ADE to provide long-term supported employment. Also provides transitional employment in a supportive environment. Has provided more than 100 jobs to jobseekers with mental illness. 70 per cent of employees have mental illness. Provides accredited training.

Business	Industry	Sponsor organisation(s)	Additional information
Incito Maintenance	Property maintenance service	WISE Employment	<ul style="list-style-type: none"> • Employees a total of 11 staff, mainly on a transitional basis. • At least 25 per cent of employees at any one time have mental illness.
Cleanable	Property cleaning and gardening service	Westgate Community Initiatives Group	<ul style="list-style-type: none"> • Established in 2005 and part funded as an ADE. • Employed 16 people with mental illness as at September 2009. • Offers long-term and transitional supported employment. • Provides cleaning services to 60 corporate clients and 80 domestic clients. • Provides accredited training to employees.
Loveluvo	Retail Manufacturer of environmentally sustainable home products	Westgate Community Initiatives Group	<ul style="list-style-type: none"> • Established in 2010. • Employs 29 workers with mental illness on a long term basis.
Bonsai	Garden nursery	Originally established by Eastern Access Community Health, Social Ventures Australia and Social Firms Australia. Now operates as a division of Knoxcare.	<ul style="list-style-type: none"> • Provides supported employment on a transitional as well as long term basis to people with psychiatric disability. • Partly funded as an ADE.
Outlook Environmental	Waste management and recycling	Outlook (disability organisation)	<ul style="list-style-type: none"> • Employs approximately 70 workers with barriers to employment, including mental illness. • Provides accredited training to employees. • Partly funded as an ADE.
MI Cleaning	Property cleaning	Mental Illness Fellowship of Victoria	<ul style="list-style-type: none"> • Provides supported employment on a long-term basis to people with mental illness • Majority of employees have mental illness.

Business	Industry	Sponsor organisation(s)	Additional information
Asteria Business Services	Property maintenance Landscaping Packaging and storage services Car wash services	Asteria	<ul style="list-style-type: none"> Partly funded as an ADE to provide long-term supported employment. Also provides transitional employment opportunities.
STREAT	Hospitality and catering	STREAT	<ul style="list-style-type: none"> Provides transitional supported employment opportunities to homeless youth, some of whom have mental illness Supported employees receive on-the-job accredited training in hospitality.
Urban Renewal	Landscaping, gardening and light construction	Mission Australia	<ul style="list-style-type: none"> Provides fixed-term, transitional work and training opportunities for previously unemployed and disadvantaged Victorians, including people with mental illness Participants gain an industry-recognised qualification in a trade where there is a current skills shortage.

Source: Compiled by Family and Community Development Committee.

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