Submission to Parliament of Victoria Inquiry into Workforce Participation by People with a Mental Illness

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1. This submission addresses each term of reference below (marked a-g and shown in bold italics). Wherever possible, the focus is on State Government rather than Federal Government, roles and responsibilities. My understanding is that the division of roles and responsibilities is outlined in the Commonwealth-State Disability Services Agreement, which currently flags disability employment services and mainstream employment services as a Commonwealth (Federal) government responsibility, and the provision of public funded mental health care, rehabilitation, and disability support services as primarily a State Government responsibility.

Terminology (adapted from section 1.3 of Waghorn & Lloyd, 2005)
2. The term mental illness refers to a set of clinically diagnosed mental disorders such as the anxiety, affective, and psychotic disorders as defined by DSM-IV and ICD-10 classification systems. The term mental illness represents more than mental health problems, a term often used to refer to short-term adverse mental health states which can occur in response to life stressors and challenging life events. Psychotic disorders typically refer to schizophrenia spectrum disorders, bipolar disorders (when psychosis is present), depression (with psychosis) and other mental disorders involving disturbances of thought and perception.

3. In the USA, the term Supported Employment refers to an approach to vocational rehabilitation emphasising ‘place and train’ in competitive employment opportunities, as opposed to 'train and place' the approach associated with traditional vocational rehabilitation. On-going assessment is conducted in real work contexts, and lengthy pre-employment assessments and gradual stepwise approaches to vocational rehabilitation are avoided whenever possible. In Australia, the nearest equivalent term is Open Employment as defined in the Australian Government's Disability Services Act, 1986. Similarly defined in this Act, the term Supported Employment refers to group-based assistance provided by Business Services, offering sheltered work in modified (not fully competitive) work settings. One or more disability categories may be accommodated by Business Services (previously known as sheltered workshops) more often for intellectual and physical than for psychiatric disability. In this report the USA meaning of the term supported employment is used.

4. Whereas occupation refers to 'any work or leisure activity', 'work' usually refers to 'any structured non-recreational activity'. Employment is a subset of both 'occupation' and 'work', and is defined by international agreement among labour market economists. Subsequently, the Australian Bureau of Statistics (ABS) use this definition of employment as being paid work of one hour or more per week in accordance with industrial awards, unpaid work in a family business, or unpaid work on a family farm. Competitive employment is a widely agreed priority for psychiatric vocational rehabilitation and is defined as: part-time or full-time work in the competitive labour market at award wages with supervision provided by personnel regularly employed by the business. The nearest equivalent official term in Australia is open employment. In competitive employment the work is to be performed alongside non disabled people in integrated settings and the job can be filled by people without disabilities. Although the job design may be modified, it is not designated exclusively for a person with a disability. Competitive employment is distinguished from sheltered work, jobs in Business Services, Social Firms, or Social Enterprises, voluntary work, unpaid work experience, or pre-vocational training. Sheltered work is characterised by one or more of: additional supervision
by mental health staff or by other staff external to the workplace; pay at less than the minimum award wage; use of a supported wage scheme; segregated work settings; or jobs reserved exclusively (or by quotas) for people with disabilities.

5. Vocational rehabilitation is another term which can cause confusion. In a general sense it refers to a form of psychosocial rehabilitation where the focus is on restoring (rehabilitating) career pathways, often in conjunction with other forms of psychosocial treatment and rehabilitation. In Australia, the term also refers to the type of vocational assistance provided by CRS Australia, as the Government owned sole public provider, where a rehabilitation partnership is developed and intensive efforts can be made to prepare a person for employment, secure employment, and provide support to achieve continuous employment for three months, or until the rehabilitation consultant is confident the position is stable. At its best, the Australian version of vocational rehabilitation is more intensive than the form provided in the U.S.A., where case loads may be higher and a limited range of low intensity assistance appears to be provided.

**Term of reference (a) Evidence of the low rate of workforce participation by people with mental illness and the social and economic costs involved.**

6. Several research reports produced by QCMHR over the past 10 years provide consistent and strong evidence that at a population level, mental illness increases unemployment (looking for work but not employed) and non-participation in the labour force (not employed and not looking for work). This effect increases with the relative severity of the diagnostic category of the mental illness, and increases with the relative severity of the work restrictions caused by the mental illness. Other variables (such as age, sex, partner status, and educational attainment) are also involved. Several of our reports have explored these issues in detail using high quality population surveys, and purpose designed surveys of people with psychotic disorders. For instance, in the most relevant four population level surveys in Australia conducted in 1997, 1998, 2003 and 2010, 16-17% of working age community residents with schizophrenia were employed, and 22% of people with psychotic disorders were employed. The international evidence from other developed countries provides a similar picture. The most relevant QCMHR reports that provide evidence for low labour force participation and difficulties completing school and higher education, are as follows:


7. In addition, the following reports investigate the correlates of labour force activity:


**Conclusions**

8. There is extensive evidence that mental illnesses have a strong and consistent impact on labour force activity, in direct proportion to the relative severity of illness and the extent of work-related disability. However, this does not mean that people with severe mental illness do not want to be employed, or cannot be employed in the competitive labour market. At a population level, it is important to note that the evidence mostly concerns people who have not previously accessed suitable assistance, or who do not currently receive assistance from a suitable employment service. In response to other terms of reference in this submission, the role of effective employment services in overcoming these population-level disadvantages will be discussed in more detail. However, our main conclusion from over 10 years of research in this area, is that the provision of effective employment services, designed specifically for people with severe forms of mental illness, can overcome all the barriers observed at an individual level even including the disadvantages associated with illness severity and psychiatric disability.

9. For a State government perspective, the main conclusion from our work is that people with the most severe forms of illness who are interested in employment are unlikely to be getting sufficient access to suitable disability employment services. This means that where other services are provided by State governments such as mental health treatment and care, case management, housing support, psychiatric rehabilitation and disability support; that these services all need to be coordinated with an effective and intensive employment service. This enables clients to form a vocational goal and get the appropriate assistance at the right time. Otherwise consumers learn that vocational goals are discouraged, because vocational assistance is either not provided, or offered years later at a much lower priority. Providing services in silos, as at present, inadvertently promotes low expectations among other services for successful competitive employment.

(b) Identification of the barriers that people with mental illness experience in gaining and retaining employment;

10. Mental illness and psychiatric disability at an individual level disrupt schooling, school to work transitions, employment, higher education and vocational training, and pathways to a career, both directly and indirectly. The direct effects are due to the impact on the person of the illness and medications, and the indirect effects are due to the negative responses of the community, including employers and providers of health and disability services, which further damage self-esteem and work-related self-efficacy. The nature of some of these barriers are described in detail in sections 6.1 to 6.17 of the following report:

11. The barriers to employment associated with specific psychiatric disorder categories, and how they can be overcome by an effective employment service are also described in detail on the Australian Government's Job Access website. The information about how barriers can be overcome for each individual, is important because otherwise the information about barriers is misleading and pessimistic. This is because the more people learn about barriers, the less they tend to believe that competitive employment is feasible. In the past 20 years, research evidence has shifted the focus from client characteristics as barriers to employment, to employment service characteristics as the main barriers. The following systematic reviews summarise the strong body of evidence based on randomised controlled trials that supports a focus on service practices rather than on client characteristics:


12. The reason for this shift is that individual characteristics (other than motivation for employment) were found to not predict competitive employment outcomes when an effective employment service was provided. This is because an effective employment service can overcome all the disadvantages and work restrictions at an individual level. This does not mean that individual characteristics are not relevant, because they are important for designing how best to provide assistance, the type and intensity of assistance needed, and the likely costs involved. In the past, individual characteristics were routinely scrutinised to assess 'work readiness' as a prerequisite criterion for providing assistance. This term is no longer favoured because the evidence now shows 'work readiness' assessments are not justified because all who want assistance (who have sufficient disability to warrant the assistance) can benefit from a zero-exclusion approach, when an effective service model is available. We also know much about the specific service practices that when used together, are a stronger predictor of employment outcomes when the focus is on volunteer clients with severe mental illness or psychiatric disabilities.

13. We have written about the challenges and rewards of implementing evidence-based approaches to the provision of employment services for people with mental illness in the following reports. Most are about Australia in particular. The more recent reports are the most relevant:


Conclusions
14. The best way to overcome barriers to employment for people with mental illness is to develop the capability of employment services to deliver services that work using the best available evidence-based practices, that are known to be most effective for the clients with severe forms of mental illness. This is important because services that operate at high caseloads and provide low intensity of services, attract clients with low and mixed severity of disorders, and may neither encourage access by clients with severe and complex forms of mental illness, nor achieve sufficient employment outcomes to counter low expectations for vocational recovery.

15. From a State government perspective this means that mental health services can promote employment and education as important options for client recovery goals in all treatment, care, and rehabilitation plans. This means 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. State governments can also encourage disability employment services to adopt the practices that work best for people with psychiatric disabilities, and not endorse employment service practices (such as sheltered employment or pre-vocational training) that are not evidence-based. In the next section we consider how States can appropriately support clients' vocational goals.

(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.

16. We have written about how State government administered mental health and rehabilitation services can collaborate effectively with Commonwealth funded disability employment services, and other essential community services. We found that the usual method of collaboration adopted by mental health services (by establishing intersectoral links) does not improve access to employment services and does not improve employment outcomes for clients of mental health services. Instead we found that formal partnerships were required to support jointly delivered mental health and employment services, and that this approach can improve client health outcomes as well as employment outcomes.

17. In a recent report (Waghorn et al., in press) the authors note: 'Establishing formal partnerships aligns closely with the first priority of Australia's Fourth National Mental Health Plan, namely to develop better mental health service structures to improve social inclusion and recovery outcomes for clients with SPMI (Australian Government, 2009a). The second action listed in this plan (p. iv) is to "Coordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs." In addition, the new National Mental Health and Disability Employment Strategy (Australian Government, 2009b) makes direct reference to the National Mental Health plan, and became demand driven from March 2010, meaning that all eligible referrals to contracted disability employment services can attract outcome-based recurrent funding.'

18. The following reports address these issues in more detail:

19. To facilitate the establishment of formal partnerships we found we needed a resource manual for clients, families, carers and clinicians to ensure everyone understood what was involved in such a program. We conducted a research project to ascertain the information needs of all stakeholders and used the information to prepare a resource booklet titled 'Building a career of your choice', which is available in hard copy from this office.


Conclusions

20. Continued segregation of mental health services from disability employment services continues to limit access to competitive employment by consumers of public mental health services. In addition, the usual approach to community collaboration between mental health and other community services, does not help mental health service clients to access suitable disability employment services, and does not help them succeed in attaining competitive employment goals. While the intersectoral links approach may be adequate for disability support, other psychiatric rehabilitation, and supported housing programs, a more formal approach is needed to integrate employment assistance with continuing mental health treatment and care. This is needed because in the early stages of employment, work performance can be addressed by both training and better treatments. This means the treatment and care team need to be involved in solving work performance problems. 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.

21. The downside is that such formal partnerships take ongoing commitment from both organisations to sustain. The partnerships need to be supported by a small local steering group, an on-site coordinator, and ongoing training and evaluation plans.

22. Where formal partnerships with mental health teams are not possible, there are other ways to improve access to vocational services and outcomes for clients with the most severe forms of mental illness. The following reports address some of those issues:

Occupational Therapy, 74(7), 339-347.

**d) The effectiveness of programs that aim to improve the workforce participation of people with mental illness, including best practice models.**

23. The following international reports address the issue of which type of programs are the most effective for volunteers with severe mental illnesses or psychiatric disability when the goal is competitive employment. The conclusion is consistent in all controlled studies, that the Becker-Drake IPS approach is typically two-three times more effective than the best alternative forms of supported employment or vocational rehabilitation.


24. The following Australian and New Zealand studies also report consistent findings with the international controlled trials. All three used different implementation methods to establish IPS, but common to each was a focus on integrating continuing mental health care with intensive employment assistance. If such integration is not attempted (see Waghorn, Stephenson, et al. 2011; Browne et al. 2009) access by approximately 60,000 clients of public mental health services in Australia will be limited. All three reports listed below have a youth focus and show that the basic program developed for adults with chronic and severe mental illness, also works well for youth with first episode psychosis.


25. The Becker-Drake IPS model of supported employment typically achieves on average competitive employment commencements for over 60% of all clients that enter the program within the first year. This compares to around 25% on average for the clients in the best available alternative supported employment services (randomised control groups). Other notable outcomes are that 43% worked more than 20 hours per week, and the mean duration of the longest job was 22 weeks (see Bond, 2004; Bond et al., 2008; and Table 3 in Waghorn, Stephenson & Browne, 2011).
DES performance
26. How does the international IPS approach compare to performance of Disability Employment Services in Australia? Table 1 shows that DES performance (Table 3.3 of DEEWR Interim Evaluation, 2011) in terms of both job commencements and 13 weeks accumulated employment. The most relevant DES comparison cohort attained less than one third of the average achieved by IPS services studied in controlled trials.

27. The most relevant cohort in Table 1 for comparison to public mental health clients with severe and persistent mental illness (the usual clients of IPS programs) is the DES-ESS (funding level 2) clients with a primary psychiatric disability (see outcomes shown in bold). We know this from several years experience tracking clients of public mental health services entering the DES system. In addition, the outcomes attained for clients with disabilities other than psychiatric, are similarly discouraging. Among the clients with psychiatric disabilities, it is particularly concerning to find that only 10.6% of the most comparable DES clients accumulated 13 or more weeks employment in a nine month period.

Table 1. Disability employment services (DES) official outcomes in 2010.

<table>
<thead>
<tr>
<th>Program name</th>
<th>Data collection period</th>
<th>Cohort¹</th>
<th>Employment outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Psychiatric disability (Primary)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Proportion commencing a job (%)</td>
</tr>
<tr>
<td>Disability Employment Services (ESS</td>
<td>9 months Mar 2010 to</td>
<td>2831</td>
<td>24.2</td>
</tr>
<tr>
<td>Funding Level 1)³</td>
<td>Dec 2010</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>18.8</td>
</tr>
<tr>
<td>Disability Employment Services (ESS</td>
<td>9 months Mar 2010 to</td>
<td>4164</td>
<td>22.5</td>
</tr>
<tr>
<td>Funding Level 2)³</td>
<td>Dec 2010</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: 1. The cohort shown in column three for each row represents new clients only. The number shown is not the total number of clients, but only the proportion with psychiatric disability as the primary disability. na = data not available. All statistics shown are derived from an official evaluation report (Table 3.3, DEEWR 2011).

28. In defense of the DES system, some might argue that the different program durations explain the differences in results. Most IPS trials reported were of 12 months duration, whereas the DES evaluation results cover only a nine month period. However, even if we adjust for this difference (assuming a roughly linear relationship between program duration and job commencements) this would only increase the DES results by 30%. This would mean the most we could expect from a 12 month period is 24.4% (18.8% x 130%) for job commencements in DES ESS FL2, and 13.8% (10.6% x 130%) for accumulating 13 weeks
employment. To be comparable with IPS results (which are typically obtained for a more challenging client mix than FL2) DES results would have to increase by around 300%.

29. DEEWR evaluation reports on DES performance are examined in more detail in a recent submission to a Federal Government Inquiry. The submission and the most recent DES evaluation report, can be found through an internet search:


30. The possible reasons for low DES performance are discussed in submission 15.1, so will not be covered again here. The important issue is that State funded mental health services can do a lot more to ensure their clients can get timely access to the most effective public funded employment services, and that the vocational plan is closely coordinated with treatment, continuing care, and rehabilitation plans.

31. We have found that community mental health teams can become more recovery oriented by establishing formal partnerships with DES services and by adopting the IPS practices which were originally designed for situations where mental health and employment services could be integrated. Good adherence or better to the core 25 practices (see IPS fidelity scale on the website of Dartmouth College, USA, Psychiatric Rehabilitation Centre) in all developed countries, correlates to average and above average employment outcomes, in the order of 3-4 times that achieved by the current DES system.

32. Once each mental health district becomes proficient in developing integrated mental health and employment services, they move to a position where they can influence employment service providers to deliver the most effective practices. In Queensland, new IPS style partnerships are formed on a mutually beneficial basis, where no money changes hands. The employment service benefits from the volunteer referrals (recurrent funding per person is available under their DEEWR contract), and the mental health service benefits from clients having access to an effective employment service. Yet the biggest benefits seem to accrue from the knowledge flow across sectors, that promotes more recovery oriented and client centred mental health services, and promotes higher vocational expectations and greater capability to deliver effective vocational services. This includes providing access to those the disability employment service might have previously regarded as too difficult to help.

33. Some may argue that there are better ways to secure employment for people with severe mental illnesses. Some may insist that segregated services are better because the mental health service is not generally regarded as a positive place for clients, and the quicker clients can be moved away from public funded mental health services the better. Others maintain that competitive employment is too challenging or too risky for the client, and prefer sheltered employment options (Business Services, Transitional Employment, or Social Firms), or prefer unemployment benefits and disability pensions for their clients. However, these views are not supported by the evidence, and systemic exclusion from the labour force is not what people with psychiatric disabilities want. Our analysis from the most recent national survey (Waghorn, Saha et al., in review) shows that 68.1% of community residents with psychotic disorders reported wanting to work in the competitive labour market.
34. Others may argue that the international results for IPS may not transfer to Australia because Australia has a more regulated labour market with award wages, and anti-dismissal legislation. However, a 12-month multisite trial in Queensland (QCMHR, unpublished randomised controlled trial, \( n=208 \)) completed in 2010, found that 56.7% of clients of the integrated service commenced employment, whereas only 33% of clients commenced employment among those referred by the mental health team to the best available local DES services.

35. There are other competing employment programs not discussed here (see Waghorn and Lloyd 2005, for a more detailed discussion). They are not included because they do not share the same goal of helping clients obtain and keep their own mainstream job in the natural community, the same as a regular citizen. Instead, other employment programs may advocate for the service provider to become the employer (as in Social Firms), to provide a community around the person, or only to provide a sheltered form of employment. Other programs may advocate for temporary employment in jobs controlled by the service provider as in Clubhouse Transitional Employment. However, this is not what we usually mean by workforce participation. The evidence shows that mainstream workforce participation is a feasible and realistic option for people with the most severe forms of mental illness, hence mainstream employment is the focus of this submission.

**Conclusions**

36. Integrated employment services coordinated by community mental health teams can provide access to consumers of public funded mental health services. Furthermore, when these are offered according to established IPS practices and utilise DES services in the partnership, the DES performance typically increases from the national average of 18.8% commencing employment to 56% or more. If others advocate for alternative programs they need to show that these are as effective with a similar client mix on the same outcome variables, while retaining a focus on the client's own job in the labour force, as the primary program goal.

(e) Opportunities for tailoring education and vocational training for the needs of people with mental illness;

37. Rather than tailoring education and vocational training to the needs of people with mental illness, the evidence we have gathered supports a person-centred approach. This involves providing sufficient assistance to enable greater access to mainstream forms of education and training. There is little evidence that establishing enclaves of people with mental illness attending modified education or training is effective. It could even be stigmatising through association. Some accommodations are clearly needed to most mainstream courses, such as part-time enrolment, multiple modes of instruction, several sources of information, library assistance, study skills training, part-time hours, and alternative forms of assessment. Staff of these institutions (such as University Disability Officers) can help students access these accommodations. Otherwise, there is little evidence that people with mental illness benefit from non-mainstream programs. However, there is a growing evidence-base that individual support for mainstream education and vocational training can be very effective. The following reports show how individual support for education and training goals can be provided.

(f) Effective measures to support employers to recruit, employ and retain people with mental illness;

38. This is an important topic about which we know very little because very little research has addressed the needs of employers. QCMHR is planning research in this area, but to date has no work in progress on employer perspectives. However, one recent research report indicates that employers need help with identifying and designing reasonable accommodations, with assessing and identifying the needs of disabled workers on the job, and with designing supervision and training plans. This USA report was not about people with mental illness in particular, yet the findings appear equally relevant to 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.

39. The previous sections also address this term of reference. There are several ways that mental health services and health professionals can drive system change towards greater workforce participation by people with mental illness. The first of these involves a recognition that there may be a culture of low expectations among health professionals that causes health professionals not to think of mainstream education or competitive employment as part of an individual's recovery plan. The evidence that this 'culture of low expectations' may exist is found in the research report below. A strong and consistent link is shown between receiving treatment for a mental illness and not being in the labour force, even after controlling for severity of illness and disability. While the cause of increased workforce non-participation when receiving treatment remains unclear, it is likely that the segregation of health and vocational services is an important factor in its origin.


40. The other ways mental health, general health and community services can help are as follows.

(a) Form formal partnerships with a DES providers whenever possible and integrate employment services with health services to high levels of fidelity with the IPS approach. If another approach is considered, ensure it is achieving similar results to IPS trials or better.

(b) Establish a Statewide support network similar to NSW's VETE program to create and nurture formal partnerships, establish common training and evaluation systems, and report on mental health service clients' vocational outcomes on an annual basis. QCMHR has developed many of the tools needed for State-wide coordination.

(c) Extend the links between health and employment to housing and other community services, learning from formal partnerships. If intersectoral links suffice, use those, but ensure
that if the client has a vocational goal this may have to take priority over other community-based goals. Hence other community services may best fit as wrap-around services to the integrated vocational and treatment service.

(d) Provide for education and training goals using a person-centred approach with existing case management or rehabilitation resources where possible. Mental health teams can lead the introduction of specialised supported education, that has no ties to a particular education institution. This is the best approach because each client has an individual path and no one institution will cater for all clients' career preferences.

Conclusions

41. In summary, there is much that mental health services can do to lead and promote the vocational recovery of people with mental illness. Although disability employment remains a Federal government responsibility, Victoria can lead the way in the State-wide implementation of evidence-based practices for people with mental illness. This can be done by requiring these practices as part of formal partnership agreements with existing DES providers, in exchange for referrals that will attract DEEWR recurrent client-based funding. Establishing and maintaining such partnerships takes an ongoing commitment and dedicated resources. However, the expected results of 50% or more volunteering clients commencing competitive employment within 12 months, is unlikely to be attained any other way.