Submission to The National Mental Health Disability Employment Strategy: Discussion Paper

June 2008

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About MHCC

MHCC is the state peak body for non-government organisations (NGOs) working for mental health throughout NSW representing the views and interests of over 200 NGOs. Our member organisations specialise in the provision of services and support for people with a disability due to mental illness. MHCC provides leadership and representation to its membership and seeks to improve, promote and develop quality mental health services to the community. Facilitating effective linkages between government, non- government and private sectors, MHCC participate extensively in public policy development.

The organisation regularly consults broadly across all sectors in order to respond to legislative reform and sits on National, State (NSW) and State Government Department (NSW) committees and boards in order to affect systemic change. MHCC manages and conducts research projects and develops collaborative programs on behalf of the sector.

MHCC thank the Commonwealth Government for inviting them to provide input into discussions for the development of a National Mental Health and Disability Employment Strategy. MHCC have consulted their members for the purposes of this submission in which we focus specifically on the experiences of people with mental illness when attempting to participate in the workforce, and address the consequential impact on the potential for recovery and maintenance of good mental health. We aim to address the barriers faced by people with disability that are obstacles to engagement in the workforce, and staying employed long-term.

MHCC participated in the consultation on 5 May 2008 hosted by The Hon Brendan O'Connor MP, and the Hon Bill Shorten MP, Parliamentary Secretary for Disabilities and Children's Services. We were pleased to hear at the consultation that the Government intend to undertake an entire review of Job Network & Disability is to be undertaken.

Background

Many people with mental illness disability have ambitions to participate in the workplace in a meaningful way. This should not be interpreted as merely a desire to fill their time, but as an indicator of their aspirations to achieve career and income objectives. Consumers regularly report that employment promotes recovery, improving the prospect of maintaining ongoing improved mental and physical health.

Consumers experience access barriers to many aspects of social inclusion that impact on their ability to overcome obstacles to employment objectives, including securing and sustaining jobs, sustainable housing, living skills, education and training, legal services, social and recreational activities. It is in the area of employment that there is the most compelling evidence linking social inclusiveness with improved mental health and recovery from mental illness.[1]

1 Bateman, J & Merton, R. (2007). Social Inclusion: its importance to mental health. Mental Health. Coordinating Council. Sydney, Australia.

It is well established that employment is strongly associated with positive mental health, including higher self esteem and sense of agency and purpose, and that unemployment degrades sense of purpose, structure, social status and sense of identity.[2] Studies have associated employment with reduced psychiatric symptoms, higher functioning, an improved sense of self worth, and a significant improvement in social skills.[3] Being employed enables social inclusion in the wider community and "represents an important way people with mental illness can meaningfully participate in society." [4] [5]

The high unemployment rate among people with serious mental illness is not an indicator of a lack of capacity to work or a lack of desire to work. People with mental illness face a number of potential barriers to engaging in work, including:

- Stigma, ignorance, misunderstanding, and discrimination can make employers reluctant to hire;
- Fear of failure in the workplace, sometimes accompanied by fear of subsequent loss of entitlements such as pensions or allowances; and
- Lack of workplaces that are flexible or accommodating to the needs associated with episodic illness.[6] [7]

Most people living with mental illness and mental health problems want to work, and consider it a feasible and desirable part of their recovery.[8] Many people do recover, and even those who have experienced the most severe forms of schizophrenia can achieve successful employment outcomes with the right support.[9]

Stigma and Discrimination

> *Employment is an area where disabled people feel discrimination keenly. Opportunities for employment have a major impact on people's lives in terms of self-fulfilment, income and interactions in society.*[10]

There is little extensive research available in an Australian context. However, evidence from the USA and the UK is considerable. According to a UK Social Exclusion Unit Report (2004), due to stigma and discrimination, both realised and perceived, fewer than four in ten employers would consider employing someone with a history of mental health problems, compared with more than six in ten for candidates with a physical disability.[11]

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2 Waghorn G & Lloyd C (2005), The employment of people with a mental illness: a discussion document prepared for the Mental Illness Fellowship of Australia. Cited in Boardman J (2003), Work, employment and psychiatric disability. Advances in Psychiatric treatment 9: 327-34

3 Frost B Carr V & Halpin S (2002), Employment and Psychosis: Low Prevalence Disorder Component of the National Study of Mental Health and Wellbeing, Bulletin 3, p 2. Commonwealth Department of Health and Ageing, Canberra.

4 Waghorn G & Lloyd C (2005), op. cit., p. 4.

5 Bateman J & Merton R (2007). Social Inclusion: its importance to mental health. Mental Health Coordinating Council. Sydney, Australia. p.26.

6 Waghorn G & Lloyd C (2005), op. cit., p. 11.

7 Bateman J & Merton R (2007), op. cit., p.27.

8 Waghorn G & Lloyd C (2005), op. cit., p. 15; Mind (2003). Mental Health and social exclusion: the Mind response. London, p. 7

9 Waghorn G & Lloyd C (2005), op. cit., p. 14.

10 Rose V & Harris E (2005). What employment programs should health services invest in for people with a psychiatric disability? Australian Health Review, 29(2): 185-188.

11 Social Exclusion Unit Report. (2004). Mental Health & Social Exclusion. Office of the Deputy Prime Minister, London. Chapter 3, p.27. Available : http://www.socialinclusion.org.uk/publications/SEU.pdf

Three quarters of employers would not consider employing someone with schizophrenia; even though schizophrenia can be controlled with medication and would not require physical adaptations to the work environment.[12]

In 1996 a survey into discrimination in the UK showed that one third of people with mental health problems report having been dismissed or forced to resign from their job.[13] Almost four in ten felt they had been denied a job because of their previous psychiatric history,[14] and more than two thirds had been put off applying for jobs for fear of unfair treatment.[15]

In the same survey, consumers had experienced negative attitudes towards people with mental illness in the community, which ranged from avoidance and prejudice to outright hostility consistent with other research findings. [16] [17]

Employment as a human right

Employment is a basic human right, identified in the various human rights instruments, including the Declaration on the Rights of Disabled Persons. Article 7 states: "Disabled persons … have the right, according to their capabilities, to secure and retain employment or to engage in a useful, productive, and remunerative occupation".[18] Notwithstanding this, everybody's recovery journey is different, and employment is not an option for all consumers. [19]

Rights and responsibilities

It is essential that staff and clients of employment services are well versed in the rights and responsibilities that we all have as members of society and that are relevant to employment services, employees and employers. Services need to ensure that policy is relevant and current and is in line with current legislation and industry standards, such as EHS.

Particularly important is the need to clearly agree with clients in what circumstances information may need to be shared with employers, other employees and carers.

Culturally appropriate services

If employment services are to respond effectively and provide equitable services for all people, it is critical that they maintain awareness of the different needs and experiences of people from a variety of cultural backgrounds. Where appropriate, recruitment of bilingual staff, liaison with multicultural agencies, and promotion of services through ethnic media can be useful strategies. It is important to have a basic knowledge of the way in which mental illness is perceived in relevant local cultures rather than relying on myths and anecdotes. [20]

12 Manning C & White P D (1995). Attitudes of employers to the mentally ill. Psychiatric Bulletin, 19 (1995): 541-543.

13 Read J & Baker S (1996). Not just sticks and stones: A survey of the discrimination experienced by people with mental health problems. London, Mind.

14 Read J & Baker S (1996), op. cit., 1996.

15 Mindout for mental health (2000). Working minds: making mental health your business. London, Mind.

16 Read J & Baker S (1996), op. cit., 1996.

17 Social Services Inspectorate. (2001). Making it Work – an inspection of Welfare to Work for disabled people. Department of Health, UK.

18 Waghorn G & Lloyd C (2005), op. cit., p. 26.

19 Ibid, p.26.

20 Faulkner A (1991). Culture, chronic mental illness, and the aged: Research issues and directions. In: Light E & Lebowitz B (eds), The Elderly with Chronic Mental Illness. Springer Publishing Company, SANE Australia (2003), op. cit., p.28.

Many standardised instruments for assessing work readiness and vocational preferences have inherent cultural biases, and therefore employment services must adopt an individualised approach taking into account the needs of people from culturally and linguistically diverse backgrounds. [21]

Barriers to employment

Many consumers experience barriers to employment and long-term participation due to the absence of the ongoing support in the education and training necessary to assist them to successfully secure skilled placements. Fear of failure in the workplace, sometimes accompanied by anxieties about possible subsequent loss of entitlements such as pensions or allowances frequently erodes the confidence needed to work since there may be times when they know they will be unable to perform work tasks and maintain health. Education rarely supports the time frames necessary for completion and qualification, and consumers report that they frequently feel set up to fail.[22]

Workplace Flexibility

Many workplaces lack the broadly flexible approach to accommodate the needs associated with people with mental illness, particularly if they experience episodic illness.[23] Whilst it may be preferable to place people and train them on the job, some may require more pre-employment training, and some may wish to check their ability to participate by the use of time-limited Transition Employment Placements (TEP). [24] This model enables clients to work alongside staff in specific units which carry out tasks necessary for the running of the program. It provides social and vocational skills, training and an opportunity to adjust to a work environment. Some people may feel happier in a peer supported environment, and others may wish to engage in open employment using the support mechanism of an employment service.[25]

Employment plans must be sufficiently flexible as to accommodate fluctuating need, and should be reviewed and modified on an ongoing basis. [26] Long-term success is often the result of a supportive relationship between an employment consultant and a consumer rather than the model or approach adopted. [27]
SANE Australia, in their Blueprint Guide to Employment and Psychiatric Disability (2003) suggest that interpretations of work readiness also need to be flexible and non-discriminatory. Confidence and skills are frequently best acquired by learning on the job.
People with a disability should not be 'written off' because of a lack experience or confidence and rejection on such grounds may have a very negative long-term impact on them.

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21 Cook, J. & Pickett, S., 1994. Recent trends in vocational rehabilitation for people with psychiatric disabilities. American Rehabilitation, 20 (4), 2-11, SANE Australia (2003,)op. cit., p.28.

22 SANE Australia (2003,)op. cit., p.29.

23 Waghorn G & Lloyd C (2005), op. cit., p. 11.

24 SANE Australia (2003). The SANE Blueprint Guide to Employment and Psychiatric Disability. Melbourne: SANE Australia, p.21.

25 Ibid, pp. 13,.22.

26 Hill R (1997). Working at work. OpenMind, 88: 12-13. UK.

27 Marrone J, Gandolfo C, Gold M, & Hoff D (1998). Just Doing It: Helping people with mental illness: Myths and facts. The Journal of Rehabilitation Counseling, 29(1), 37-48.

Employment services need to support clients to overcome their fears and lack of skills and experience by encouraging them to move into some form of employment as soon as they feel able.[28]

Consumers not yet ready to enter the workforce should still be able to access services such as intensive support, further education and training opportunities Likewise employment services need to be flexible enough to allow people to 'fail', re-evaluate their situation and re-enter the workforce at another stage, rather than focusing on organisational measures of success as 'throughput.' [29] It is quite usual for people in the community to move from job to job until settling on a career path, especially when young. If a person with a psychiatric disability does this, they risk being labelled unstable or unable to hold down a job.

Acknowledging that employment services are operating in a competitive marketplace, they need to balance being flexible and inclusive with ensuring people are realistically prepared for work in the competitive open job market, in other words, striking a balance between 'supporting and enabling'.[30]

Gaining employment

Shaheen and colleagues, with reference to a number of other studies, identify the following factors that contribute to successful employment outcomes for people with mental illnesses:

- Employment services experienced as part of an overall integrated recovery plan;
- A consumer-driven approach, with emphasis on consumer preference and practical assistance with finding jobs;
- Ongoing assessment and support based on individual needs and preferences; and
- Services that understand the specific issues around work and mental illness, and that value the individual consumer driven approach.[31] [32]

Employment is only one component of individual recovery, each component needs to operate in an integrated manner alongside secure housing and other social support services in a whole of person approach. [33]

Evidence has shown that success is frequently dependent on partnerships and networks. Frost (2002) cites the success of the Hunter Psychiatric Employment Panel, a partnership between NGOs, Government and the community Mental Health Service. This was a consumer-focused program directing individuals to the most appropriate services according to individual needs. In its first two years, it successfully placed 76.5% of clients in a combination of open employment, work skills development, and mainstream educational services.[34]

28 SANE Australia (2003) op. cit., p.22.

28 Ibid, p.21.

29 Hardy J (1993). Employment and Psychiatric Disability: Report Summary and Re commendations. AGPS. Cited Ibid, p.22.

30 O'Flynn D & Craig T (2001). Which way to work? Occupations, vocations and opportunities for mental health service users. Journal of Mental Health, 10 (1), 1-4.

31 Shaheen G, Williams F & Dennis D, eds (2003). Work as a Priority: a resource for employing people who have a serious mental illness and who are homeless. US Department of Health and Human Services, p.32.

32 Bateman J & Merton R (2007), op. cit., p.28.

33 Ibid, p.28.

34 Frost et al, (2002), op. cit., p.2.

Unsurprisingly, factors found to contribute to successful employment retention among those recovering from mental illness are closely aligned to those factors that promote good mental health in the workplace for the whole community. These include: training and support, supportive interpersonal relationships, flexibility, workplace culture, and a management culture with a genuine interest in the employee's welfare.[35]

Outcome Evaluation

Quality management requires that evaluation of employment services measure outcomes for all clients irrespective of the level of disability. Agencies cannot develop and improve service delivery unless ongoing evaluation is built into the service, with the capacity to undertake a process that is planned, structured and systematic. Only in this way can they provide feedback to funding bodies, measure the impact of services delivered and measure the efficiency and utilisation of resources. Critical to this process is measurement of consumer satisfaction which can be undertaken with the use of numerous instruments. Likewise, the process is only useful if seen as a tool for quality improvement and implementation and not merely the collection of data.[36]

Policy Context

People with mental health disabilities are not doing well in the new 'Welfare to Work' environment because their particular needs are not taken into account. The development of a Disability Employment Strategy is a welcome Government initiative in which MHCC hope to see intensive, ongoing consultation with representative consumers and specialised service providers so that the complexity of need is heard.[37] We suggest that critical to the success of such a strategy is that a radical agenda for National leadership is evolved across government for cultural change in service delivery.

Government needs to appreciate the fundamental difference between mental health and physical disability as they relate to employment. It is critical to identify what works well for this client group, identify services that have achieved successful outcomes such as targeted support services, and build models around these success stories. A variety of models needs to be developed that address the complexity of need and support, the range of psychiatric disability is broad and there is 'no one size fits all' solution.

In addition to employment, education and participation in recreational, leisure, and/or work-readiness programs, have all been shown to contribute to improved self-esteem and quality of life. It is in this critical policy context for a Social Inclusion Disability Employment Strategy that MHCC propose that policy be embedded in an across government approach that widely encompasses: housing, education, living skills, community participation, financial services and benefits, employer engagement, community attitudes (stigma and discrimination), ethnicity, the criminal justice system, and includes the voice of carers and families.

Recommendations in this document aim to address key policies and drivers in respect of employment, in particular how these harness, engage, compliment and contribute to the Employment Strategy for people with Mental Illness.

35 Secker J & Membrey H (2003). Promoting mental health through employment and developing healthy workplaces: The potential of natural supports at work. Health Education Research, 18(2): 207-15

36 Fabian E (1999). Rethinking work: The example of consumers with serious mental health disorders. Rehabilitation Counseling Bulletin, 42 (4), 302-310.

37 Consultation Phil Nadin, Vice Chair Psychiatric Rehabilitation Association.

Evidence based models

In the Welfare to Work environment, systems designed around the current set of outcome measures and efficiency indicators will continue to discriminate against those who most need service. Employment support systems need to encourage people to participate and keep them engaged, rather than presenting opportunities for disengagement due to non-compliance.

Community based mental health organisations support the concept of a two tiered system for people living with mental illness. Each has its own purpose and appropriate target group.[38] No time limits should apply to either tier.

1. **Open Employment** (termed "supported employment" in the US and much of the literature) refers to assistance provided to help consumers obtain and retain employment in the competitive job market.

2. **Supported Employment** (also known as "transitional employment" or "vocational rehabilitation") covers a range of models providing high support and skills training, usually in a non-competitive work setting.[39] [40]

Regardless of the model, having some form of direct support for individuals has been shown to significantly improve the rates of securing and retaining work. For many, this in turn has been shown to be a key component of successful social engagement and recovery.[41]

Open employment in particular has a strong evidence base. To date its success has been supported by several randomised controlled trials and other studies comparing it to other approaches to seeking employment.[42]

Based on findings of four studies and nine randomised controlled trials on open employment in the USA, Bond (2004) found that 40% - 60% of consumers obtained competitive employment compared with less than 20% of those who were not in such a program. He further found that consumers who retained competitive employment for a sustained period of time, demonstrated benefits such as improved self esteem and control of symptoms.[43]

Another study, looking at the 10-year outcomes of clients who participated in supported employment in the early 1990s, found that the benefits of supported employment lasted for the longer term, with participants reporting successful competitive employment and substantial improvements in self esteem, hope, relationships, and control of substance abuse.[44] [45]

38 Penrose-Wall J and Bateman J (2006). Working on Strengths: Models of assistance by mental health community organisations, and evidence of their effectiveness. Mental Health Coordinating Council, Sydney, Australia, pp. 21-25.

39 See Waghorn C and Lloyd S (2005), op. cit., pp. 5-6.

40 Bateman J & Merton R (2007), op.cit., p.29.

41 Ibid, p.29.

42 Bond G, Salyers M, Rollins A, Rapp C, & Zipple A (2001). How evidence-based practices contribute to community integration. Community Mental Health Journal 40(6): 569-588.

43 Bond G (2004), Supported employment: evidence for an evidence-based practice. Psychiatric Rehabilitation Journal, 27(4): 345- 349.

44 Salyers M, Becker D, Drake R, Torrey W, and Wyzik P (2004), A ten-year follow-up of a supported employment program, Psychiatric Services 55(3): 302-8

45 Bateman J & Merton R (2007), op. cit., p.28.

A 2004 UK study found there was no strong correlation between consumers' psychiatric diagnosis and their work performance, and many consumers performed better than had been expected. The reasons for this were attributed to consumers' gains in confidence, motivation, and self belief.[46] [47]

An important part of the mix of opportunities available to enable clients to engage in the workforce, are consumer run businesses that provide the support and peer mentoring of great benefit to consumers. Likewise, a social firm model piloted by the Mental Health Fellowship Victoria, based on an Italian model is an approach that operates in the open market with limited government support employing at least 30% of workers with a disability.[48]

Volunteer work also provides an opportunity to 'test the water' for many consumers, whilst participating in meaningful work, gain skills and experience whilst offering flexibility. However, it is critical that such opportunities also offer mentoring and vocational development for the volunteer.

For those consumers for whom open employment is not an option, support in acquiring social skills and other basic work skills can be achieved through transitional or sheltered employment. Such opportunities can help with developing self esteem and personal growth.[49] [50]

Community collaboration

Employment services need to work closely with clinical services to help clients manage and maintain their mental health in the workplace.[51] Similarly they need to ensure they maintain close relationships with the local support service network, as well as the local business community to ensure a holistic approach to clients' needs. Life outside of work can have a negative impact on a person's ability to find and maintain a job.[52]

Consumer participation

It is critical that people with a psychiatric disability be given genuine opportunities to participate in service development, that involvement is flexible, appropriate and not tokenistic. Consumers interested in involvement of this nature may require support and training in order to do so, and should be encouraged to see the benefits in their so doing, providing valuable input into service delivery processes and relationship building with staff and networks. [53]

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46 Stepney P and Davis P (2004), Mental health, social inclusion and the green agenda: an evaluation of a land based rehabilitation project designed to promote occupational access and inclusion of service users in North Somerset, UK, Social Work Health Care 39(3-4): 375-397

47 Bateman J & Merton R (2007), op. cit., p.28.

48 Cook J & Pickett S (1994). Recent trends in vocational rehabilitation for people with psychiatric disabilities. American Rehabilitation, 20 (4), 2-11.

49 Waghorn C and Lloyd S (2005), op. cit., p. 16.

50 Bateman J & Merton R (2007), op. cit., p.28.

51 Bond G, Becker D, Drake R, Rapp C, Meisler N, Lehman A, Bell M & Blyler C (2001). Implementing supported employment as an evidence-based practice. Psychiatric Service s, 52(3), 313-322, op. cit., SANE Australia (2003), p.26.

52 Marrone J & Gold M (1994). Supported employment for people with mental illness: Myths and facts. The Journal of Rehabilitation, 60 (4), 38-48, op. cit., SANE Australia (2003), p.26.

53 Hardy J (1993). op. cit., SANE Australia (2003), p.27.

Workforce development

MHCC emphasise the importance of a strong focus on building the capacity of employment agencies to increase their mental health literacy. The Vocational Education and Training (VET) sector through DEEWR has prioritised the 'up-skilling' of clinicians. This is a role duplication within the workforce, with an expectation that clinicians will take on the same role as an employment worker. We suggest that it is far more appropriate for employment services to assist people with mental illness to access employment opportunities with the support of clinical services. Importantly, many people managing their mental illness may not be engaging with clinical services. These clients require support from employment agency workers with a good understanding of mental health issues.

Conclusion

Current federal and state government funding arrangements represent a barrier to employment for people with mental illness. Split departmental responsibilities create barriers to employment service delivery when health, education and employment services are required simultaneously across several sectors and agencies. The system acts as a disincentive for people to move between potential avenues of assistance.[54] Mental health related services tend to operate at 'silos' making it hard for people with mental illness navigate the system and receive consistent support. Many consumers fall through the gaps in service delivery or exit the system in frustration.

There is an urgent need for improved connectedness between different services and access to appropriate services requires greater collaboration between state and federal governments. Without this, any objective for a consumer-oriented and connected mental health system will not be achieved. [55]

An additional obstacle to collaboration between services is that employment services are funded by the Commonwealth and the majority of mental health services are funded by state governments. Competing funding arrangements, policy priorities and responsibilities do not create the ideal environment in which cooperation can occur.[56]

The National Action Plan on Mental Health 2006-2011 and the National Mental Health Strategy 2003 (National Mental Health Plan 2003-2008) emphasised delivering connected services for people with mental illness and recognised the challenges of collaboration, these collaborations have not been adequately evaluated and largely have not eventuated.[57]

A strong message received during consultations was that for a long time placement itself has been the measured outcome rather than the retention that required ongoing support. Indeed the existence of a service frequently has depended on achieving a set number of placements without consideration to the sustainability of those placements. Consumers who have 'failed' become casualties who often are disinclined to try again and if they do may receive negative responses from service staff who perceive them as a risk.[58]

54 Mental Health Council Australia (2007). Let's get to work. A National Mental Health Employment Strategy for Australia, p.33.

55 The Boston Consulting Group (2006). Improving Mental Health Outcomes in Victoria: The Next Wave of Reform. Report to the Government of Victoria, Boston Consulting Group, Melbourne, Victoria. Cited in Mental Health Council Australia (2007). Let's get to work. A National Mental Health Employment Strategy for Australia, p.33.

56 Waghorn C and Lloyd S (2005), Mental Health Council Australia (2007). op. cit., p. 38.

57 Ibid.

58 Ibid.

The cost of mental illness to the community in terms of dollars is enormous, to people with psychiatric disability and their families inestimable. The argument for additional investment in mental health services to improve outcomes, in particular investment in measures that specifically facilitate economic participation is therefore compelling.[59]

Recommendations

1. That a two tiered strategy be developed that encompasses both an open employment model and a supported employment model

2. That a supported employment model includes a number of variations to match individual need. This would include Transitional Employment Placements, consumer run businesses and social firm models.

3. That the supported employment tier include supported volunteer placements

4. That services are flexible and adopt a individual focus when working with clients

5. That support in open employment is ongoing rather than time-limited to meet the needs of the individual

6. That disclosure of disability rests with the individual in negotiating placements with employers

7. That services develop strong links with local businesses to market the benefits of employing people with a mental illness, and support employers when problems arise in the workplace

8. That services help employers to develop policies that reflect commitment to diversity and eradication of stigma and discrimination in the workplace and the community

9. That services support employers with backfill when consumers become unable to work

10. That employment services develop close links with clinical and community services as well as training providers, educational facilities and business and commercial associations

11. That employment services ensure consumers are active participants in the development, implementation and assessment of their work placement

12. That employment services ensure consumers are active and not tokenistic participants in the policy development and systemic reform of the services that they engage with

13. That employment services and clients create and maintain current policy regarding rights and responsibilities and ensure employers and employees are fully aware of the contents and meaning of policy

59 SANE Australia (2003), op. cit., p.33.

14. That employment services ensure a safe environment in which cultural and gender differences are promoted and respected

15. That employment services undertake to recruit quality staff with a wide diversity of skills and experience across the sector and the ability to work with the client group in appropriate and respectful ways

16. That evaluation processes are embedded into operating structure of employment service organisation

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