

Tell them they're dreaming

Work, Education and Young People
with Mental Illness in Australia



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Abbreviations

ABS – Australian Bureau of Statistics

COAG – Council of Australian Government

DES – Disability Employment Service

DES – DMS – Disability Employment Service Disability Management Service

DES – ESS – Disability Employment Service Employment Support Service

DEEWR – Department of Education Employment and Workplace Relations

DSP – Disability Support Pension

ESA – Employment Services Area

ESAt – Employment Services Assessment

FMHSS – Family Mental Health Support Services

IPS – Individual Placement and Support

JCA – Jobs Capacity Assessment

JSA – Job Services Australia

JSCI – Job Seeker Capacity Instrument

MHR:CS – Mental Health Respite: Carer Support

NDIS – National Disability Insurance Scheme

NESA – National Employment Services Association

OECD – Organisation for Economic Co-operation and Development

PhaMs – Personal Helpers and Mentors

PSP – Personal and Social Performance

SACES – South Australian Centre for Economic Studies

SEE – Skills for Education and Employment

SSSO – Student Support Services Officers

VCAL – Victorian Certificate of Applied Learning

Executive Summary

Young people with mental illness want to work. They hold this as their number one goal, in common with older adults with mental illness and adults in the general population without mental illness. They long for the benefits of employment that include but are not limited to wages. They hold a great desire to live independently and to participate in their communities. Despite their dreams of a working, contributing life, the bleak reality for a young person developing a mental illness is that their life is more likely to be characterised by unemployment than employment, by the receipt of benefits rather than the earning of a wage. This state of affairs brings with it a number of significant costs. These include the lost potential of the individual, their lost contribution to society and enormous economic costs. This report examines why this is so and makes recommendations that aim to remedy this situation.

Why does mental illness lead to poor educational and employment outcomes for young people?

Mental illness is the illness of young people. Most onset of mental illness occurs in adolescence and early adulthood. About 75% of mental disorders will have developed by the age of 25 (McGorry et al 2011).

Because of the age of onset there are often negative impacts on educational attainment and the transition to the workforce. For example more than 65% of people with a psychotic illness have not completed Year 12 (Waghorn et al 2012). In the general population, as well as the population of people with mental illness, it is a well-established fact that more education protects against unemployment and is associated with higher incomes.

As well as education and training being interrupted or prematurely exited, there are numerous other barriers to employment such as stigma, workplace discrimination and welfare traps.

As a consequence people with mental illness are severely disadvantaged in the workforce. Employment statistics illustrate they have consistently low labour market participation rates and stubbornly high unemployment rates.

What is currently done to address this?

Presently, educational interventions are piecemeal and dependent on local champions. They suffer from a lack of resources and consequently don't deliver for young people with mental illness.

The employment services system is supposed to help people with disabilities including people with mental illness find sustainable jobs. However, employment outcomes for people with mental illness are woeful. One metric of the failure of these services is that the employment level of people with psychotic illnesses has not changed over a ten-year period, stuck at 22% (Waghorn 2012 et al). Employment outcomes for people with mental illness more generally, are also poor. For example in 2009, only 29.2% of people suffering from a psychological disability were participating in the workforce and 18.9% of those were unemployed (ABS 2009). This does not compare well to other disability groups (Ibid.).

Employment outcomes in the Disability Employment Service from March to December 2010 for people with mental illness were equally unsatisfactory: of the 4,001 people with a psychiatric disability enrolled in the DMS program only 26.6% (1,066) were placed in a job and only 14.2% (568) reached the 13 week outcome (DEEWR 2012).

As a consequence of these poor outcomes it is not surprising that there is growth rather than reduction in the proportion of people with mental illness in receipt of the Disability Support Pension. They simply have no bridge to reconnect them with the workforce that they want to be a part of, and no viable alternative pathway to pursue in order to avoid needing the DSP in the first place.

In short, the current vocational support systems fail young people with mental illness, condemning them to a marginalised and stigmatised life with reduced opportunity for social and economic participation.

What contributes to this situation?

Access: Currently an individual needs to be receiving a welfare benefit to access employment support services. Many young people in the early phases of mental illness are not yet accessing benefits as their family is supporting them. This requirement excludes them from accessing employment services at the earliest opportunity. Access is further hampered by the assessment and classification process. It has been estimated that in at least one-third of cases this process is misclassifying individuals with severe mental illness and consequently directing them to less intensive employment supports than they require (Waghorn et al 2012).

focuses on job readiness despite literature suggesting on-the-job experiences at work are more effective.

What does the evidence suggest?

There has been significant research into the model of employment assistance called Individual Placement and Support (IPS) (Drake et al 2012). This evidence-based employment intervention for people with mental illness has shown remarkable success both in Australian and international trials. The model averages employment outcomes almost three times the current services (Bond et al 2012). Australian and international studies have shown that for young people with severe mental illness, the success rates can be as high as 85% (Killackey et al., 2008; Neuchterlein et al., 2008). IPS adapted for young people additionally includes a focus on educational as well as employment outcomes (Chinnery and Killackey, 2014). A key element of IPS is that the service is provided as a fully integrated element of mental health treatment. Providing evidence-based vocational assistance early in the course of mental illness is crucially important for two reasons. Firstly it is known that the experience of any mental illness before age 25 is associated with more unemployment, more underemployment, lower wages and greater welfare support (Gibb et al., 2010). Secondly making an early functional recovery in severe mental illness – that is getting back to school or work – is more predictive of long-term outcomes than making an early

“So I said to her I’d really like to go back to school and get a job, and she said ‘with your condition? You’re dreaming love. The best thing you can do is just rest’”

Client recounting a conversation with a relative

Service factors: The payment structure, particularly for disability employment services, is biased towards the provision of services rather than the attainment of outcomes. This creates a situation where agencies can still be rewarded financially without necessarily achieving employment outcomes for their clients. Similarly the fostering of competition among service providers has led to a reduction in co-operation and sharing of knowledge about ways to succeed for clients. Additionally, there are high administrative loads that restrict the time that front-line staff are able to spend assisting job seekers, as well as high caseloads that dilute the intensity of services received. Finally, the current employment services also use an approach that

symptomatic recovery (Alvarez-Jimenez, et al., 2012). The evidence therefore suggests that IPS should be available to young people with mental illness early in the course of their illness, and in a way that is fully integrated with their mental health treatment. In practice this would mean that IPS was provided in and by the mental health service rather than by third party agencies contracted to provide employment assistance.

Implications of the Budget on the recommendations of this report

In the 2014 Federal Budget, introduced on May 13, it was announced that people on a DSP, who are aged under 35, and who commenced on the DSP before 2011 would need to have their capacity to work reassessed. It is

possible that many of the people who will be reassessed as being able to work will have a mental illness as their disability. This report already recommends that young people, who we have classified as below 25, who have a mental illness and are in receipt of a benefit should have their capacity to work reassessed at regular intervals in the context of assisting them to realise their dreams and achieve full social inclusion. However, this is only half of the solution. These people must then be linked with an effective means of locating employment, education or training. As discussed in this report, we do not believe that the results to date of the Disability Employment Services give any confidence that these agencies will be able to deliver significantly for young people with a mental illness. The policy announced in the budget makes more important our suggestion that Individual Placement and Support employment services be established and delivered through headspace (for those under 25) and through community mental health settings for those over 25. IPS is the bridge that links the vocational aspirations of people with mental illness, to the employment market. The risk of not building this essential bridge between policy and outcome is that negative consequences ensue. These are likely to be increased feelings of helplessness, rising disability and the very real possibility of increased premature death from suicidal behaviour. Ensuring easy access to high-fidelity IPS through headspace for those under 25 and community mental health settings and primary care for those over 25 will contribute greatly to the successful realisation of the government's policy goals. More importantly it will allow people with mental illness to achieve their educational and employment goals.

Summary

For young people the onset of mental illness consigns their hitherto realistic hopes of the future to unattainable dreams. The systems that should prevent this from happening, that should support, guide and shepherd these young people through this transitional phase of their lives are broken. There are no coherent or systematic policies to support the completion of education. The employment system derives significant income from this group in return for precious little. Change is urgently needed and this change must be aligned with the onset of these vocational problems, in the early stages of mental illness. This report examines the employment and welfare system in relation to young people with mental illness and education and employment. It makes a number of recommendations

which we hope will allow people at the outset of a mental illness to not lose their dreams of the future, but to turn them to reality with all the individual, societal and economic benefit that will bring.

Key Recommendations

This report presents a number of recommendations that are detailed in the Section 6. However the key steps to helping young people with mental illness realise their employment and educational dreams are:

- Fund high fidelity IPS employment and education services to be provided to young people presenting to headspace centres around Australia. These services would be fully embedded and come under the governance of headspace. This could be funded from a range of current funding sources.
- Use the headspace national dataset to capture the data about an integrated model and use this to evaluate and refine the provision of these services.
- Using lessons from the scaling up and implementation of IPS at headspace centres, expand IPS services into mainstream community mental health services for all mental health consumers who wish to work or return to study.
- Develop anti-stigma campaigns targeting employers, families, young people and primary care providers to break down attitudes that imply that young people with mental illness cannot or should not work.
- Educate mental health clinicians about the importance of employment and education as a part of, not the product of, recovery. Such a program to be led by the National Centre of Excellence in Youth Mental Health.
- Through the provision of comprehensive early intervention services that address both symptomatic and functional needs, provide a viable pathway to return to employment and education.

Introduction

This report addresses disadvantage in employment and education faced by young people aged 12-25 years with mental illness. It has a specific emphasis on this age group because mental illness has its peak onset in youth, and as a consequence the normal process of vocational development is disrupted. Intervening early to address disrupted vocational development is likely to have significant individual, societal and economic benefits.

The paper begins with a brief overview of the characteristics of mental illness, the prevalence of conditions and associated costs.

The second section of the paper sets out the difficulty people with mental illness encounter at school and examines current education policy and program settings before describing possible solutions to current shortfalls.

The third section looks at disadvantage experienced in employment by people with mental illness, overcoming barriers to work and the current employment services available to people with severe mental illness. It then looks at the design issues found in employment services and offers recommendations to ameliorate the situation.

The fourth section of the report introduces and describes a variety of evidence-based employment services and defines a path to implementing these services in Australia.

The fifth section proposes a novel approach to education and employment interventions in Australia for young people with a mental illness.

Recommendations arising from the report are in Section 6 and the report is concluded in Section 7.

Why are education and employment important?

Accepted wisdom is that people with mental illness either can't or shouldn't work. This is simply not true. The former position relies on the false argument that people with mental illness in the workplace are unreliable, poor employees and possibly dangerous. The latter argument, that people with mental illness should not

work, relies on the idea that work is inherently stressful, that the stress of it will lead to relapse. In turn the relapse will lead to the loss of the job, which will compound feelings of failure and poor self-esteem. In short, work for people with mental illness should be avoided. These widely held views underpin the actions of otherwise well meaning clinicians, family members and other carers and young people with mental illness themselves. They are also at least partially responsible for the rapid growth in people with mental illness being in receipt of the Disability Support Pension (DSP). Subsequently, if work is not to be a feature in the life of people with mental illness, the unspoken corollary is that there is little point in wasting too much effort on education – the foundation of career. Consequently, while there is some evidence for employment supports for people with mental illness, there is next to no evidence on which to base educational interventions.

And yet education and employment are important to people with mental illness, and in particular young people with mental illness, for all the same reasons as they are important to people in the general community who do not have mental illness. As well as providing a wage, which is a key factor in establishing independence, employment is the royal road to social inclusion. Further, the positive effects of work on mental health include an association between employment and improved quality of life and wellbeing (Marwaha et al 2008). Work is also associated with better physical health, more and better social relationships, community participation and is key to the development of a socially valued identity. Education is indispensable to vocational development in maximising the opportunities that the individual will have to enjoy meaningful and rewarding employment. Links between educational attainment and sustainable

outcomes in employment are well known (Waghorn et al 2012).

In the past, for people with mental illness, work was seen as something to be possibly engaged in only after recovery. Increasingly participation in work and education are seen as key elements of the recovery process – as important interventions for wellness in and of themselves. In this way it is similar to the changed message about injured backs in which the focus is now on a speedy return to work rather than a

the worst labour force participation rates of people with any disability, and high unemployment levels. Unemployment rates rise rapidly following the onset of mental illness (Rinaldi et al 2010), quickly followed by transition to disability pensions (Ho & Andreason, 2005). People with mental illness are the largest and fastest growing disability group in receipt of the DSP in Australia. Studies following cohorts with mental illness starting on disability pensions note that over up to 5-year follow-ups, few people transition back off a disability pension (Ho & Andreason, 2005). This accords

“The Strategy will help ensure that policy settings, including health, education, employment and income support systems and infrastructure are properly designed to help meet the aspirations of people with disability, and to maximise productivity across all sectors of the population wherever possible”

(Commonwealth of Australia, 2011, p18).

prolonged absence. Another way to think about this is that the onset of mental illness can be an extremely de-normalising time. People typically turn stigma in on themselves and believe all the stereotypes about mental illness apply to them – that they are other than normal. There is no intervention in all of mental health's armamentarium as powerfully normalising as the offer by someone to pay you for your labour after a competitive job selection process.

Additionally, consumers themselves report that employment and education are important. Studies tell us that unemployment is associated with worsening psychological illness and increasing social exclusion (McKee-Ryan et al 2005). People with lived experience don't need a study to tell them this. They know. Consequently, even at the outset of illness, the desire to complete education, get work and enjoy the benefits such as independent housing and social relationships outrank symptom recovery as goals (Iyer, 2012; Ramsay, 2012). Studies estimate that between 70% (Drake et al 2012) and 90% of people with mental illness want to work (Killackey 2014).

So what's the problem?

Despite wanting to work and complete education and training, people with mental illness have low levels of completion of secondary education, among

well with data showing that in Australia the two most common exits from the DSP are death and the aged pension (Department of Social Services 2013). Given the early onset of mental illness, an individual may potentially spend more than 40 years on the DSP. This represents an avoidable personal and economic disaster. However, the system that should do most to prevent this situation, the Disability Employment system fails at this task in relation to people with mental illnesses.

Disability Employment Services are intended to provide the ongoing and proper level of support for people with severe mental illness. Yet, positive employment outcomes for people reporting a psychiatric disability in the service are far too low. It has even been suggested that people with severe mental illnesses actually do better in finding work themselves than they do with the help of disability employment services (Waghorn 2011). Contributing reasons to these poor outcomes will be discussed in Section 3.

Is there a solution?

Currently in Australia employment services use a “train and place” approach that revolves around building work readiness before entering competitive employment. This contrasts with vocational models based on the “place and train” philosophy. There has been a shift in the literature in recent years toward approaches that

focus less on pre-employment training and more on building work skills in the competitive labour market and real-world on-the-job training while providing concurrent supports (Drake et al 2003).

Analysing education settings as well as employment services with a view to creating more effective and supportive systems is paramount to addressing social and vocational isolation and allowing Australians with mental illness to build the base platform from which to pursue their life goals.

It is also important to look at the settings around the Disability Support Pension to ascertain whether any policy levers could be used to better reflect the needs of people suffering mental illness. This paper will look at evidence based employment interventions and disability targeted education systems in an attempt to tackle the variety of problems facing government in this sphere.

In addition there are a number of existing policies that will contribute to the solution. The Australian Government's National Disability Strategy exemplifies the push to improve employment outcomes for disabled people and should be the basis of policy settings for people suffering mental illness.

The fourth National Mental Health Plan sets out five priority areas for policy reform around social inclusion and recovery, prevention and early intervention, service access, quality improvement and innovation and accountability.

Despite the presence of some policies that may help in addressing this issue, it must be remembered that people with mental illness as a disability group have not benefited from any of the various changes in employment policies over the years. While being open to the positive potential of existing policies, in order to produce an effective and sustainable solution it may be necessary to imagine and design new policies and means of delivering services. To continue to fund systems that do not and have not worked for people with mental illness is a disservice to a population eager to work and must be seen for the wilful wastage that it is.

Reducing isolation, financial disadvantage and other problems associated with mental illness is not only vital to improving the lives of young people with mental illness but also to improving productivity and sustainability of the Australian economy and society.

“A mental health system that enables recovery, that prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.”

(Commonwealth of Australia, 2009, pii)

Section 1: The illness

This section discusses the prevalence and characteristics of mental illness in Australia, the associated costs and current treatment rates. It examines unintended effects of current Medicare arrangements for young people accessing psychological services and proposes changes to encourage and increase take-up of mental health services among adolescents through the removal of barriers to early intervention.

Prevalence and characteristics

Around half of the 16 million people in Australia aged 16-85, or 7.3 million people, will experience a mental disorder in their lifetime and around 20% or 3.2 million people suffered from a mental illness in the 12 months prior to 2007 (ABS 2007). Approximately 14% of 12-17 year olds and 27% of 18-25 year olds have mental health or substance abuse problems each year (headspace 2011). Mental health conditions and substance use disorders are responsible for 60-70% of the burden of disease for 15-24 year olds (Ibid.).

There are a number of different kinds and varying severities of mental illness. Severe and enduring mental illness usually refers to conditions such as schizophrenia, bi-polar affective disorder, severe depression and anxiety (Mental Illness Fellowship of Victoria 2013). Despite the serious nature of these disorders and the massive impact they can have on a person's life they can be managed and controlled through the use of medication, therapy, self-care routines, support networks and clinical care. People with severe mental illness are still capable of achieving their goals of participating fully in society and living fulfilling lives.

There are several key characteristics of these illnesses that should be taken into consideration when formulating effective mental health policies. The onset of most psychiatric disabilities occurs during adolescence (McGorry et al 2011). This has repercussions for a person and their engagement with their education. It also means the period of transition between formal education and employment can be substantially more difficult for people suffering from mental illness.

Most mental illness is episodic. Someone suffering from a severe psychiatric disorder may experience periods of significant disruption and illness that make work seem like a distant dream but there are also times when the person will feel relatively unhindered. Conditions can be manageable and with treatment and support many people will be able to reduce the length of periods of sickness and extend time between episodes of the illness (Mental Illness Fellowship of Victoria 2013).

Commonly associated with a variety of mental illnesses are negative symptoms such as a lack of motivation, a lack of enjoyment and low levels of confidence (Mental Illness Fellowship of Victoria 2013). These can be crippling but avoiding social isolation and providing proper care is vital to ameliorate the worst effects of mental illness. Support networks such as friends and family, encouragement, good clinical treatment as well as fulfilling activities such as employment or further education can be incredibly valuable and help overcome these negative symptoms. However, even the best treatment can still sometimes not be enough to completely stop symptoms such as hallucinations (Mental Illness Fellowship of Victoria 2013).

Costs associated with mental illness

Mental disorders represent the largest cause of disability in Australia and account for 13.1% of the nation's burden of disease (Commonwealth of Australia 2012). This leads to an estimated \$20 billion cost to the economy each year in lost productivity and labour force participation (Ibid.).

Annual costs of psychosis are significant. The 2010 Australian National Survey of Psychosis found a cost to society of \$77,297 per affected person per year. This was made up of \$40,941 in lost productivity, \$21,714 in health sector costs and \$14 642 in other sector costs. According to the report, health sector costs are 3.9 times higher for people with psychosis than for the general population. It also pointed to a cost of \$4.91 billion per annum to the Australian society and a \$3.52 billion annual bill for government (Neil et al 2014). This represented minimal change from the survey done in the year 2000 (Ibid.). Increases in cost per person for ambulatory care, non-government services and pharmaceuticals were offset by a halving of inpatient costs and an 84.6% decrease in costs associated with crisis accommodation (Ibid.).

Productivity losses remained fairly stable over the previous decade illustrating the size and consistent nature of employment disadvantage faced by people with a mental illness. The lack of improvement in employment outcomes and productivity losses is especially worrying considering significant changes in policy since the first survey. There was a reduction in national unemployment, several national mental health strategies and significant work on the disability employment services (Waghorn et al 2012).

Given the lack of improvement in sustainable employment outcomes for people with mental illness it is important to look at improvements to vocational assistance. Tackling barriers to competitive employment is paramount both for the health of individuals and the budget bottom line.

Treatment rates and disease burden

Mental illness represents the third largest disease burden in Australia (Waghorn & Lloyd 2005). It trails cardiovascular diseases and cancer in terms of morbidity and mortality. In terms of morbidity, mental illness is the leading burden of disease in Australia (Ibid.).

Anxiety, depression and substance use represent a leading disease burden but evidence points to a lack of treatment. Even though it is well known untreated disorders incur major economic costs and personal anguish, only a third of people with these illnesses access treatment (Whiteford et al 2014).

This is despite a major policy shift in 2006 that saw the creation of the Better Access Medicare Benefits Schedule

that allowed psychologists, some social workers and occupational therapists to claim Medicare rebates for patients referred by GPs. This has seen an increase in treatment rates for all mental disorders from 37% in 2006-07 to 46% in 2009-10 an increase achieved in no other country (Ibid.). People being treated using Better Access has risen from 10.1% in 2006-7 to 27.6% in 2009-10 (Ibid.). While this represents a significant improvement it is concerning that the majority of people suffering mental health problems are still not seeking treatment.

Policy Implications

Early intervention is a key plank of the Australian Government's National Mental Health Plan. Its positive effects are numerous and well documented. This includes mounting evidence that specialised early intervention mental health services can provide increased employment. However, according to the evaluation of the Better Access scheme young people are still using psychological services at a lower rate than the rest of the population. While this has improved since the scheme was introduced there is still work to be done.

To give people the best chance to overcome and manage their illness and be self-reliant, we should improve access to psychological and psychiatric services as early in life as possible. One barrier that is particularly problematic for young people is the significant Medicare co-payment required to use these services. Whilst there is currently bulk billing available for some services, the rates at which bulk billing occurs are vastly different between GPs and mental healthcare providers. General Practitioners providing mental health care consultations bulk bill 90.2% of the time while the average co-payment is \$18.58 (Department of Health and Ageing 2007). This compares to psychological consultations, which are bulk billed 25.9% of the time and attract an average co-payment of \$27.97 (Ibid.). Psychiatrists bulk bill 29.9% of the time and on average charge a co-payment of \$65.10 (Ibid.).

While co-payments might not seem large and prohibitive, a young person with no or a very low income may be put off even by the smallest charge. Without support from parents the payment for services is a barrier to accessing treatment for young people. Two mechanisms could address this issue. The first is to require bulk billing of relevant services to eliminate the cost to the target user group. The second is to increase

payments to service providers as compensation for the elimination of the co-payment, with the loss of earnings due to the abolition of the co-payment for this age group overcome by the subsequent increase in usage.

Recommendation

Create a new Medicare benefit class for people under the age of 25 receiving treatment that either:

- requires bulk billing; or
- provides psychologists and psychiatrists with a slightly higher payment in exchange for getting rid of co-payments.

Section 2: Education and mental illness

This section of the report sets out the disadvantage people with mental illness face at school, which has obvious implications for employment later in life. The report looks at the current education policy framework by describing key Commonwealth initiatives and several programs in New South Wales and Victoria. The paper then briefly describes specialist mental health staff in other States and Territories before suggesting recommendations to improve educational attainment for people with mental illness.

Disadvantage at school

Disadvantage is keenly felt in the area of educational achievement. The vast majority of mental illness has its onset in adolescence and early adulthood. Often this can derail a young person's education leading to a competitive disadvantage in seeking employment (McGorry et al 2011). Each year around one in four young Australians experience a diagnosable mental illness (Ibid). Among people aged 15-25 years, mental-health and substance-use disorders account for over 50% of the burden of disease (Ibid). This along with the fact 75% of these disorders will have developed by the age of 25 illustrates the importance of early intervention (Ibid). Psychotic disorders typically have their onset between the ages of 10 and 30 which is a critical time in terms of completing formal education and setting up career pathways (Waghorn & Lloyd 2005).

The 2009 Australian Bureau of Statistics (ABS) Survey of Education and Training found 38% of 20-24 year olds with a mental illness had not completed Year 12 and had no plans for further education compared to 25% of people with other disabilities or long term health conditions (ABS 2009).

In 2003 63% of people with psychological disability reported no post-school educational attainment compared to just over half of people with physical disabilities (ABS 2003).

Ill health and disability were reported as barriers to educational attainment for 7% of 15-24 year olds with a mental illness or nervous conditions compared to 3% for other long-term illnesses (ABS 2009).

In addition a survey of people with psychotic disorders found that 18.4% had difficulty reading or writing and only 31.9% had completed high school (Waghorn et al 2012). The study found links between educational attainment and employment status. It illustrated that engagement of disadvantaged students is vital to improving work prospects into the future. People with severe or very severe mental illness were more than twice as likely to be employed if they held a high school qualification (Ibid). The link was even more obvious among people with illnesses that had a lesser impact on their functioning. People with good to very good global functioning experienced a jump from 6.6% employed to 28.5% employed if they had a high school qualification or better (Ibid).

Thus levels of high school completion for people with mental illness are between 32% and 62% depending on illness. This compares to a Year 12 completion rate of 78% for all 20-24 year olds in 2010 (ABS 2011). Besides highlighting the source of their competitive disadvantage with respect to employment, these figures also illustrate that while a variety of policies are aimed at improving educational attainment and engagement for people with a mental illness, there is clearly a long way to go.

Education policy framework:

School education is a state and federal responsibility. The Commonwealth Government provides funding to

levels of high school completion for people with mental illness are between 32% and 62% depending on illness. This compares to a Year 12 completion rate of 78% for all 20-24 year olds in 2010. (ABS 2011)

both public and private schools predominately through State Governments. Each school also has significant autonomy as to how programs are delivered.

All governments in Australia are facing increasing fiscal pressures due to the growth of expenditure exceeding the growth in revenue. In addition the vertical fiscal imbalance means that States and Territories are under significant pressure to fund expensive education initiatives, especially without the financial support of the Commonwealth.

In addition, there are a variety of Commonwealth funded programs aimed at engaging adolescents in education. Each State also has individual strategies aimed at ensuring disadvantaged students have the supports they need to access a good education.

This section will set out the Commonwealth programs and look at some of the State initiatives aimed at engaging adolescents with mental illness and helping them get a high quality education.

Important Commonwealth education policy initiatives

School funding

School funding has recently undergone sweeping changes. The new Better Schools agreement is based on a report chaired by David Gonski and provides resources based on schools' level of disadvantage. The Report's goal was to provide equity in schooling so all children have access to high quality education regardless of where they live and what school they attend.

The Commonwealth gives schools money based on an amount it calculates is needed to educate a child each year. The Schooling Resourcing Standard (SRS) sets base funding amounts with additional loadings provided based on students and schools that need more support.

The previous Australian Government committed itself to \$3.1 billion over the forward estimates and an additional \$8.3 billion in years five and six (ABC 2013). The current Government has indicated it will honour the first four years of the funding agreement but has not disclosed its position for additional funding past the forward estimates (Ibid.).

National Partnership on Youth Attainment and Transitions (January 2010 – December 2013)

The Council of Australian Governments (COAG) agreed on a national partnership to improve educational attainment and better the transition between school and further education, training or employment. The agreement has a particular focus on 15-24 year olds and young people at risk of disengagement from school.

The goals of the National Partnership are:

- To lift the Year 12 or equivalent attainment rate to 90% by 2015
- To provide an education entitlement to young people
- To better engage young people with education
- To help 15-24 year olds transition from schooling to further education or employment
- To align Commonwealth, State and Territory programs related to young people

The National Partnership has five elements:

- Individualised support for at risk young people through the Youth Connections program
- School, business and community partnership brokers
- Maximising Engagement, attainment and successful transitions (State and Territory government responsibility)
- National career development
- The Compact with Young Australians

Youth Connections

Youth connections is a program aimed at helping young people overcome the barriers that make it difficult to stay in or return to school. The Government has allocated \$286.8 million over four years to this program (Department of Education 2011). The program is available to young people at risk of disengaging or who have already disengaged from school as well as their family. The program is delivered through individualised case management with flexible one-to-one services to help keep adolescents engaged with education or further training. A Youth Connections provider can also help a young person reconnect with family, find a mentor and put a young person in contact with mental health, literacy and numeracy services.

In 2010 more than 21,000 young people received individual support through the program including nearly 5,000 clients (23%) with a suspected or diagnosed mental health issue (Submission 62, 2011).

School Business Community Partnership Brokers

This program was funded with \$182.9 million over four years (Department of Education 2011). It aims to support and create partnerships between schools, business, community organisations and families. This is in an attempt to improve transition outcomes for young people leaving school.

Compact with Young Australians

As part of the National Partnership agreed to at COAG, young people and particularly early school leavers are targeted by the Compact with Young Australians. The compact includes:

- A requirement to stay in school until at least Year 10 and participate full-time (at least 25 hours a week) in education or training until aged 17.
- An entitlement to an education or training place for all 15-24 year olds. This is particularly focused on achieving Year 12 or equivalent outcomes.
- Increased participation requirements for people under 21 years of age without Year 12 qualifications who are in receipt of government benefits like Youth Allowance.

National Disability Insurance Scheme

The NDIS will provide funding for supports that enable eligible participants to attend school education. The money will aid people with severe mental illness engage in a range of activities.

The funding will help provide a range of supports including (Commonwealth of Australia 2014):

- Assisting students at school with self-care needs
- Specialised support to transition between schools or from school to tertiary education
- Specialist transport required due to disability
- Equipment required due to disability such as wheelchair or personal communication device

This is in addition to supports that are already funded through the education system. These include (Ibid.):

- Learning assistance or teachers aids
- Adjustments to school curriculum
- Supervision to address behavioural issues and school participation

More Support for Students with a Disability

The Australian Government has provided \$300 million over three years, which is due to end in 2014 (Department of Education 2013). This money is for support services for students with a disability. All eight State education departments and 16 non-government education authorities have agreed to implement plans to provide supports such as:

- Health or allied health specialists within a school
- Individual curriculum differentiation to better engage people with a disability or learning difficulty
- Technology that helps students to learn in the classroom

Each authority sets out details of what is being provided in progress reports (Department of Education 2013).

Centrelink

Centrelink provides payments to help young people between the ages of 15 and 24 continue education and training such as Youth Allowance, ABSTUDY and the Early Study Payment. The agency also provides information on programs aimed at education and training such as Youth Connections and the Australian Apprenticeships Access Program.

Australian Apprenticeships

The Australian Apprenticeships Access Program is aimed at vulnerable job seekers and can help people access apprenticeships, find employment or get into further training. It is specifically targeted at early school leavers, people who are homeless and mature age job seekers (Department of Industry 2013). The program provides pre-vocational training, job search support and post-placement support (Department of Industry 2013).

Australian apprentices with a disability can also access additional assistance under the Australian Apprenticeships Incentives Program. The supports include Disabled Australian Apprentice Wage Support which is paid to employers and mentoring/tutorial services (Department of Industry 2013).

There are also additional supports available through JobAccess, Job Services Australia or Disability Employment Services. Particularly through the Employment Assistance Fund, job seekers with a mental illness can access money to buy work related services (Department of Industry 2013).

The Australian Apprenticeship Mentoring package consists of the Australian Apprenticeships Mentoring program and the Australian Apprenticeships Advisers program.

The Mentoring program supports around 10,000 apprentices with around 330 mentors each year. This is targeted at industries with skills shortages and apprentices facing barriers to participation such as people with a disability. The program is designed to aid in the retention of apprentices at risk of dropping out and is funded until 2015.

The Advisors program was part of the 2011 budget and was in response to the Apprenticeships for the 21st century expert panel report. Twenty-one million dollars was provided over a two year period (2011-13). It is aimed at providing advice and information to people considering an apprenticeship (Department of Industry 2013). No further projects will be funded under this program.

Skills for Education and Employment (SEE)

Previously known as the Language, Literacy and Numeracy Program, the SEE program is aimed at improving the language, literacy and numeracy of job seekers who are finding it hard to obtain employment. Job seekers are referred by the Department of Human Services (Centrelink), Job Services Australia providers (JSA), Disability Employment Service providers (DES) and Remote Jobs and Community program providers. Job seekers must be 15-64 years old, not a full-time student, registered with an employment service provider and receiving a social security benefit (Department of Human Services 2014). People in the program can access up to 800 hours of free training delivered in full-time or part-time hours (Department of Industry 2013).

The program is capped and aims to achieve 30,000 new commencements in 2014-15 and is funded to achieve at least that number of new commencements each year (Department of Industry 2013).

Mindmatters

Mindmatters is a program with a whole-of-school approach aimed at improving the school environment, implementing curriculum materials aimed at mental health awareness, increasing student resilience and teacher development for mental health promotion in schools (URBIS 2011).

National School Chaplaincy Program

This program helps schools access a chaplain or pastoral care worker to support student wellbeing. Funds are provided to both government and non-government schools to establish or enhance chaplaincy services (Submission 62, 2011).

State and Territory education initiatives

Each State and Territory has different policies aimed at engaging young people with their education and keeping adolescents at school. It is outside the scope of this report to analyse each policy individually but a snapshot of initiatives in New South Wales and Victoria will illustrate the current landscape.

New South Wales

In NSW there is a wide range of student welfare services available within and to schools including (URBIS 2011):

- Students with a disability can access supports in their school through specialist services. There is assistance provided through the Learning Support Teams which help teachers to address the needs of students with a disability, learning difficulty or behavioural disorder.
- Peer mediation aimed at reducing violence, truancy and vandalism in schools.
- The Child Wellbeing Unit within the Department of Education. This is comprised of three teams which include seven Assessment Officers and a Child Wellbeing Consultant (senior psychologist).
- The curriculum and staffing model is designed so students are taught by one or a small number of teachers. Additional support is provided through the Integration Funding Support program. Money from this program is designated for additional teacher time, training and school learning support officer time.
- School learning support team. This team is made up of a team facilitator, school counsellor, teacher representatives and specialist personnel such as carers or English-as-a-second-language teachers.
- Student learning and support coordinators. These specialist teachers provide support for classroom teachers and students.
- Learning assistance program which helps students from Kindergarten to Year 12 having difficulty with literacy, numeracy or language regardless of the cause.

School-Link

This program was launched in 1999 and aims to improve the mental health of students (URBIS 2011). The NSW Department of Education in collaboration with the NSW Department of Health provide a framework for mental health services and schools to promote mental health, facilitate early identification and assist students suffering from mental illness (Ibid.). There are three main areas:

- Strengthening formal and informal links between mental health services and schools.
- Training mental health workers and school counsellors
- Supporting implementation of mental health initiatives including prevention and early intervention.

School Counsellors in NSW

School counsellors in NSW schools have qualifications in teaching and psychology. They are school-based and provide counselling and psychological assessment services to students. Figures from 2009 show there are 790.8 full time school counsellor positions in the NSW public school system (Ibid.). Counsellor positions are allocated based on need, numbers of students with a disability and socio-economic disadvantage and are supervised by District Guidance Officers (Ibid.).

In NSW, there is an average counsellor/student ratio of 1:1,050 and reports have indicated counsellors spend the bulk of their time doing assessment with little time for preventative and support services (Ibid.). The NSW Commission for Children and Young People recommended the ratio be improved to 1:500 (Ibid.).

Victoria

A report by the Auditor General in 2012 identified that 1 in 5 students require assistance at school (Victorian Auditor General 2012). Victoria has a range of policies aimed at supporting the welfare of students. These include:

- Student Support Services program. This program cost \$66 million in 2011 (Victorian Auditor General 2012). Student Support Services Officers (SSSO) help through early intervention with students at risk of disengaging, develop capacity within schools to deal with students requiring additional support, aid in overcoming learning barriers and respond to critical incidents involving students and teachers. The SSSOs have qualifications ranging from psychologists and social workers to speech pathologists and guidance officers. The Victorian Education Department estimates one in five students will need to access the

Student Support Services program at some stage in their schooling however in 2011 there were only 627 SSSOs and 540,000 students in Victorian government schools (Ibid.). This equates to a ratio of one SSSO for every 172 students who need access to the program or one SSSO for every two schools (Ibid.).

- Student Welfare Coordinators. This is aimed at addressing truancy, bullying, drug use and depression (URBIS 2011). Schools administer funding provided by the State Government for this initiative.
- Primary Welfare Officers. This position is filled by either an existing staff member with health, social work or mental health experience. The Primary Welfare Officer aims to foster a better environment at schools and to support students at risk of disengagement.

Victorian Certificate Applied Learning (VCAL)

VCAL offers an important option for students at risk of disengagement. This is reflected in the student cohort enrolled having characteristics identified with groups at risk of disengagement (Victorian Auditor General 2012).

In 2011 there were 13,858 public school students enrolled in VCAL representing a 60% increase since 2006 (Victorian Auditor General 2012). According to the Victorian Auditor General's 2012 report, in 2010 87% of intermediate or senior students enrolled in the program went into work or further training (Victorian Auditor General 2012). However, recent cuts to the program have affected the feasibility of students trying to attain a secondary school certificate through VCAL (Victorian Auditor General 2012). Completing senior or intermediate VCAL provides an alternative senior secondary school certificate.

Education programs for students using mental health services

There are a several schools students can be referred to once they are involved in mental health services. The student remains enrolled at their mainstream school but can receive additional assistance through supported education settings available at the following schools:

- Travencore School
- Austin School
- Avenues Education
- Baltara

These schools provide inpatient school support for students undergoing treatment for mental illness.

Programs such as those found at the Travencore School in Victoria offer important specialised mental health programs for students receiving treatment for psychiatric conditions.

Other State and Territory specialist mental health staff

For a summary of all relevant policies in other States and Territories refer to the Psychological and Emotional Wellbeing needs of Children and Young People: Models of Effective Practice in Educational Settings report produced by URBIS for the NSW Department of Education and Communities (URBIS 2011). Here is a quick snapshot:

South Australian wellbeing staff:

- Guidance officers
- School counsellors. Teachers employed in primary and secondary schools many of whom have no formal training in psychology.

Queensland wellbeing staff:

- Guidance officers
- Chaplains
- Community education counsellors
- Regional behavioural management staff

Western Australia wellbeing staff:

- School psychologists
- Pastoral care provided by teaching staff
- School chaplaincy program

Australian Capital Territory wellbeing staff:

- School counsellors with qualifications in psychology and teaching
- Student management consultants

Northern Territory wellbeing staff:

- School psychologists – registered with NT Psychologist's registration Board
- School Counsellors

Tasmania:

- School psychologists – must hold teaching qualifications and be registered

Policy Implications and recommendations

There are clear links between educational attainment and success in the workforce. School offers a great opportunity for students' needs and issues such as mental illness to be recognised and addressed. While there are a variety of different policies and services available in each jurisdiction, students with mental illness are still facing serious barriers in their education.

Resourcing education programs for young people with mental illness is an issue across Australia. While the need for such services is clearly understood there appears to be a lack of consensus or evidence around which programs are the most effective and where funding should be aimed.

Effectiveness of selected policies and guidance to support students with special learning needs

Area of policy/guidance	Comprehensive	Well understood by schools and regions	Consistently implemented by schools and regions
Applying for Program for Students with Disabilities funding	✓	✓	✓
Accessing student support services	✓	✓	✓
Establishing student support groups and outlining members roles and responsibilities	✓	✗	✗
Developing and using individual learning plans	✓	✗	✗
Full time enrolment requirements	✓	✗	✗
Complaints	✓	✗	✗
Restraint and seclusion practices	✗	✗	✗
Parent payment for additional support	✗	✗	✗

Source Victorian Auditor-General's Office

Programs such as those found at the Travencore School in Victoria offer important specialised mental health programs for students receiving treatment for psychiatric conditions. These programs are vital and funding them sufficiently is important. However, they require students to already be engaged in mental health services and treatment. This means students at risk of disengagement, suffering from mental health disorders that are yet to need or seek treatment cannot be serviced through these schools.

There is also a gap between policy and practice. This is best illustrated by the graphic above from the Victorian Auditor General.

Bridging the gap between policy and practice is vital if changes to the system are to have the desired effect.

Recommendations

- Develop a nationally consistent approach to funding and supporting programs aimed at engagement and wellbeing to address inadequate funding and reduce differences between jurisdictions in policy and practice.
- Improve staff to student ratios in important programs such as Student Support Services Officers through increased funding attached to disadvantaged students and schools.
- Improve funding structures for alternative education settings which deal with students who are receiving clinical treatment.
- Develop supported education policies in mainstream settings for students before they are referred to mental health services with funding structures which allow for growth.
- Continue to work with schools, students and parents to promote mental health literacy and enhance resilience and support teachers to recognise issues and refer students with mental illness to someone better placed to treat the condition.

Section 3: Employment and people with mental illness

This section of the report describes levels of disadvantage encountered by people with mental illness in relation to employment. The report then looks at overcoming various barriers to employment and describes current support settings. After a thorough description of current employment services the report will move to a discussion of employment outcome results and policy initiatives aimed at improvements for people with mental illness using the services.

Employment Disadvantage

There is a growing body of evidence that suggests current policy settings are not addressing employment disadvantage among young people facing significant vocational barriers due to psychiatric disorders.

The labour force characteristics are alarming. In 2003 the Australian Bureau of Statistics reported that people with a psychological disability had the lowest participation rate of any disability group at 28% and the highest unemployment rate of all groups at 19% (ABS 2005).

Australian Bureau of Statistics data from 2009 reported 369 600 people with a psychological disability (ABS 2012). This made up 17% of all people with a disability. In 2009 29.2% of people suffering from a psychological disability were participating in the workforce and 18.9% of those were unemployed (Ibid.). This does not compare well to other disability groups. People with brain damage, head injury or stroke (155,600) made up a smaller proportion of the total disabled population in Australia but report a higher labour force participation rate (35.6%) and a lower unemployment rate (15.3%) (Ibid.). People with a physical disability (1,546,000) were even better off with 49.7% playing some part in the work force and 7.5% unemployed (Ibid.). The labour force participation rate for people without a disability in 2009 was 82.8% with an unemployment rate of 5.1% (Ibid.).

In terms of severe mental health problems, a 2012 Australian study found only 22.4% of people with psychotic disorders were employed part or full time (Waghorn et al 2012). This study showed that there has

been no real change over a period of 12 years since a similar study in 1998 found an employment rate of 21.1% among Australians with psychotic illness (Waghorn et al 2004). This compares to a report in the UK that found 27% of survey participants with a psychotic disorder were employed (Ibid). In the USA the results were worse with 20.5-22.5% of people with schizophrenia employed (Ibid). While psychosis is much rarer than conditions such as anxiety, its effects are profound. In 1998 75.2% of householders with psychosis were unemployed and not looking for work, 21.1% had jobs, and 3.7% were still searching (Ibid.). This emphasises the lack of change in employment outcomes over the last decade and a half even as program and labour market conditions have shifted.

Rinaldi and colleagues have documented that a rise in unemployment predates accessing treatment and rises rapidly through the early course of illness (Rinaldi et al 2010). This again emphasises the need to address vocational issues early in the course of illness.

The Reserve Bank of Australia (RBA) recently released a report looking at economic disadvantage and unemployment. The report notes that the impacts of long term unemployment are “a depreciation of skills, reduction of social networks and adverse consequences in terms of health outcomes and life satisfaction, all of which impede the task of finding employment” (Cunningham et al 2014 p29). Given that poor work-related skills and a lack of social networks

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it is well known that unemployment for members of the general population is stressful, associated with poorer physical and mental health and family and relationship breakdown. It is a strange form of bigotry that assumes that this would not also be the case for unemployed people with mental illness who wish to work

are characteristics of people suffering from mental illness, this is likely to multiply the difficulty in obtaining employment for people with psychiatric conditions who are long-term unemployed. Further, Alvarez-Jimenez and colleagues have shown that making a functional recovery – that is getting back to school and work – early in the course of illness is actually more predictive of long term outcome than making an early symptomatic recovery (Alvarez-Jimenez et al 2012).

Overcoming barriers faced by people with mental illness

Entering the workforce offers the ability to build financial independence and benefit from social inclusion. It is therefore vital that the proper support systems are in place to help people suffering mental illness get back to work.

There are a variety of barriers separating people with mental illness from the labour market. The most recent National Survey of Psychosis asked people outside the labour market their reasons for not looking for work. Responses were not mutually exclusive. The most common answers were “own ill health or physical disability” (80.1%), “not wanting to work” (31.9%), “lacks necessary schooling, training, skills or experience” (24.5%) and “welfare payment/pension may be affected” (23%). A further 9% of people with psychosis not looking for work said having to care for children was the reason (Waghorn et al 2012).

There are significant other barriers to employment. Perceptions among health professionals that patients cannot benefit from work can act as a powerful disabling influence on people with mental illness. The Mental Illness Fellowship's research shows often those closest to the person suffering from mental illness worry about the negative effects returning to work might have on their loved one (Mental Illness Fellowship Victoria 2013). This coupled with advice from clinicians that full-time work will be too stressful and will never be achieved is a barrier that could be broken down by

better understanding. For example it is well known that unemployment for members of the general population is stressful, associated with poorer physical and mental health and family and relationship breakdown. It is a strange form of bigotry that assumes that this would not also be the case for unemployed people with mental illness who wish to work.

People suffering mental illness often face significant stigma and discrimination in the workplace and in the general community. In fact, anticipation of discrimination has been shown to deter two thirds of people with mental illness from applying for work (Thornicroft et al 2009). Countering stigmatising attitudes can be difficult and is an ongoing challenge. Efforts around mental health awareness are important in tackling this barrier. A report released in 2008 examining employer attitudes says “it would be helpful to educate the community that mental illness is not a person's choice or ‘fault’; mental illness is a medical condition that is manageable and can be treated” (DEEWR 2008 p17). Employment specialists can also play an important role. Strategic disclosure to employers and educating the workforce and wider community can counter stigma (Waghorn & Lloyd 2005). Waterhouse looked at issues around disclosure from the employer's perspective and concluded non-disclosure is an issue that makes the job of managers more difficult and employer understandings of what mental illness is problematic (Waterhouse et al 2010). Improving support structures and employment opportunities will help people with mental illness demonstrate their work potential and overcome commonly held misconceptions.

A lack of coordination between treatment and vocational rehabilitation interventions can act as another barrier to employment goals (Waghorn and Lloyd 2005). Changes in medication and dosage can produce additional difficulties in finding and keeping work as the side effects of antipsychotic, and anti-depressant medications can cause challenges (Rutman 1994).

The current state-federal funding arrangements and administrative structures spanning several departments create additional barriers to employment for people suffering mental illness. Accessing employment services, benefit payments, healthcare and educational services requires coordination across various agencies and levels of government. A young person with mental illness, despite being the person least capable, is then

responsible for managing all these services across various agencies. Integrating employment services with clinical treatment teams and including counselling around benefits and education opportunities could help improve outcomes. These are key elements of the Individual Placement and Support method of employment support which is discussed further in Section 4, below.

Disability Support Pension

Welfare payments to people with a disability accounted for \$14.9 billion last financial year (Commonwealth of Australia 2013-14). This was paid to 821,738 people. In 2013, those suffering from psychological and psychiatric illness made up the largest category receiving benefits (256,380 people, or 31.2%) and accounted for 17,348 or 31.5% of successful new DSP applicants, up from 24% in 2006 (Department of Social Services 2013). The proportion of people with mental health problems receiving the disability payment has been increasing since 2001 and in 2011 for the first time surpassed those with musculo-skeletal and connective tissue conditions as the main category of DSP recipients. As mentioned research has shown a rapid progression of young people with mental illness onto disability pensions (Ho and Andreason)

In 2008-09 64.5% of applications for disability payments were successful. By 2012-13 the rate at which people were granted the DSP had fallen to 43.3% (Department of Social Services 2013). This is likely to be related to the introduction of new assessment procedures and revised impairment tables in 2011.

More than 91% of DSP recipients said they had earned no money in the fortnight before the 28th of June 2013 (Department of Social Services 2013).

Basic conditions of eligibility for DSP (Department of Human Services 2014):

- Over 16 but under the aged pension age
- Physical, intellectual or psychiatric condition assessed at 20 points or higher on impairment tables and as a result the person must be unable to work 15 hours or more per week for the next two years.
- The person must also, due to their condition, not be able to undertake training to build skills necessary to work.

The maximum basic rates for the DSP are as follows (Department of Human Services 2014):

- Single aged under 18 living at home receives \$345 per fortnight (independent \$532.60 per fortnight)
- Single aged 18-20 dependent \$391 per fortnight (independent \$532.60 per fortnight)
- Single aged over 21 receives \$751.70 per fortnight
- A member of a couple receives \$566.60 each per fortnight

Payments are subject to an income test (Department of Human Services 2014). A person can earn up to \$156 per fortnight without their payments being affected. A single person's benefit will reduce to zero dollars if they earn \$1,810.20 per fortnight (Ibid.). An independent person aged 16-20 can earn up to \$1,251.80 per fortnight before their pension is reduced to zero (Ibid.).

There is an assets test on DSP recipients however it does not take the family home into consideration (Ibid.). If a person with a home has assets above \$196,750 then for every \$1000 of assets they have above this amount their pension is reduced by \$1.50 per fortnight. The level for single non-homeowners is \$339,250.

DSP recipients can work up to 30 hours each week and continue to receive a part pension as long as they still meet the income test requirements (Ibid.). If a person works more than 30 hour per week their pension will be stopped but can be restarted if they reduce their workload within two years (Ibid.).

There are participation requirements for DSP recipients under 35 who are assessed as being capable of some work, study or volunteering (Ibid.). Recipients assessed as having a work capacity of 8 or more hours per week and are not working must attend regular participation interviews with Centrelink to develop a plan setting

Integrating employment services with clinical treatment teams and including counselling around benefits and education opportunities could help improve outcomes

making a functional recovery – that is getting back to school and work - early in the course of illness is actually more predictive of long term outcome than making an early symptomatic recovery

out activities to help the person get involved in the community (Ibid.). The person must meet with Centrelink every three months after the first interview and after 18 months the meetings become six monthly (Ibid.). If a person is working at an Australian Disability Enterprise, in the Supported Wage System or has a dependent child under 6 years of age they are exempt (Ibid.).

At the participation interviews information is provided to DSP recipients on the impact of employment on payments and the programs available to find work. They also talk about community activities and volunteering. The person develops a participation plan with Centrelink based on their specific circumstances.

Targeted Community Care (Mental Health) Program

The Targeted Community Care Program (TCC) is made up of three initiatives. They are the Personal Helpers and Mentors program, Mental Health Respite Carer Support and Family Mental Health Services. The objective of the TCC program is to provide community mental health initiatives aimed at supporting people with mental illness, their families and carers (FAHCSIA 2012).

Personal Helpers and Mentors (PhaMs)

In 2011-12 \$82.5 million was allocated to 175 PHaMs services (Ibid.). There was also an additional \$154 million over five years to employ an additional 425 PHaMs workers nationally (Ibid.).

This program provides one on one assistance to people with severe mental illness aged over 16 (Ibid.). It is aimed at overcoming social isolation, increasing community connectedness and helping people achieve personal goals and manage everyday tasks (Ibid.).

Mental Health Respite: Carer Support (MHR:CS)

The 2011-12 budget provided \$50.3 million for 190 existing MHR:CS providers (Ibid.). There was also \$54.3 million provided in the budget over five years to give

around 1,100 families and carers access to support services (Ibid.).

The program provides flexible respite services for carers of people with severe mental illness or an intellectual disability. This is aimed at supplementary care arrangements to assist families and carers in their roles. Aside from carer support, services can include counselling, advocacy and mental health education.

Family Mental Health Support Services (FMHSS)

The 2011-12 budget allocated \$15.9 million for existing FMHSS services and an extra \$61 million over five years to establish 40 new FMHSS services (Ibid.).

The service provides early intervention and support to help families with children suffering mental illness. The services are aimed at reducing the stress associated with supporting a child with mental illness and recognise the integral role strong supportive families play in an individual's recovery.

JobAccess

JobAccess is a Commonwealth Government initiative to support the employment of people with a disability. The website provides a comprehensive list of services and programs for people with disabilities. This includes information for employers about mental illness, information for job seekers ranging from health professionals, accommodation, and mentoring as well as workplace mental health programs.

Disability Employment Services (DES) and Job Services Australia (JSA):

The following section will describe the DES and JSA systems including assessment processes used to classify job seekers into the most appropriate service, the performance tools used to evaluate services and the funding structures.

Employment services in Australia predominately use a train then place model. Job Services Australia providers predominately work with less disadvantaged job seekers and Disability Employment Services assist people who face larger and more numerous barriers to the labour market.

Both DES and JSA operate in a quasi-market. For-profit and not-for-profit organisations are contracted by the federal government to supply employment services. These contracts set out performance standards, rules for the provision of vocational support and conditions on payment for service. The Department of Social Services administers DES and the Department of Employment takes care of JSA.

Job Services Australia overview

Around 700,000 Australians receive employment services through the JSA at any point in time (DEEWR 2012). Upon the establishment of JSA in 2009 the federal government committed more than \$6 billion over four years (Commonwealth of Australia 2012-13). There are more than 100 contracted providers across more than 2000 sites Australia wide (Jobs Australia 2013).

JSA is split into four streams of support. Stream one is for people who are relatively close to the employment market with clients facing progressively more barriers the higher the stream they are placed into.

Disadvantaged job seekers in the JSA system are placed into stream two, three and four. Stream four is designed for people with a disability and or significant social barriers while stream three is for other people at high risk of long-term unemployment.

JSA provides time-unlimited support in the job search but limits assistance to six months at work.

JSA providers work with job seekers to understand employment goals and skill levels in order to develop an Employment Pathway Plan. This details the training and support provided and sets out agreed activities the job seeker will undertake to tackle their individual barriers to employment. Changes in a job seeker's circumstances are discussed with employment specialists and assessment tools used to ascertain whether the client needs more help and whether they need to be moved to a stream offering greater assistance. Any non-compliance is reported by the JSA provider to Centrelink.

The Employment Pathway Fund is a highly flexible resource used by JSA providers to buy things that the job seeker needs. This includes paying for training courses, transport costs, work clothing and other items to assist in overcoming barriers to employment.

The Work Experience Phase is a period during which eligible job seekers in streams one to four must undertake work experience. This is in an attempt to help the long term unemployed gain work skills to move the job seeker closer to the employment market.

Disability Employment Service overview

At November 2010 there were 143,983 people enrolled with a DES provider which were split relatively equally over the two programs offered DES-DMS and DES-ESS (DEEWR 2012). The Commonwealth Government is

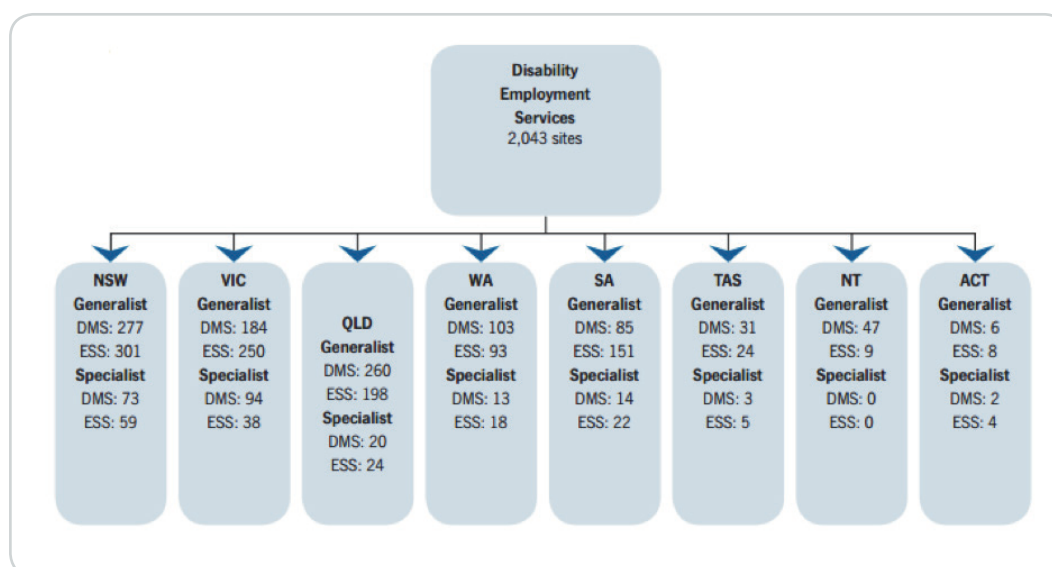


Figure 1: DES provider sites (Reproduced from Evaluation of Disability Employment Service 2012 by DEEWR)

expected to spend more than \$3.2 billion over the four years from 2012-13 on the program (DEEWR 2012-13). Around 31% of DES participants have a psychiatric disability (DEEWR 2012). Most people in DES are on the Newstart benefit (Ibid.).

At the end of November 2010 there were 221 DES providers across 2,043 sites Australia-wide. This included 66 DMS providers and 207 ESS providers. Providers often offer more than one service.

DES has three different streams of services. Ranging from least intensive to most intensive - Disability Management Service (DMS), Employment Support Service (ESS) Funding Level one and Employment Support Service Funding Level two. DMS provides assistance in obtaining employment while ESS includes ongoing support to find, get and maintain work. Payments for service and outcomes increase as services are intensified.

Both types of employment assistance, DES-DMS and DES-ESS, provide up to 78 weeks of pre-employment support. DES providers can claim six quarterly service fees with an additional two quarterly service fees (26 weeks) made available if the job seeker is found to be in need of extended assistance. Once the job seeker finds work they move into the Post Placement Support phase. This includes payments to providers for job placement, 13 week and 26 week pathway or full-outcomes. Once a program participant has reached the 26 week employment milestone there is the option of ongoing support. In the DMS service, flexible ongoing support is provided if needed with an Ongoing Support Assessment every 52 weeks. The DES-ESS services are similar in structure but have the option of flexible, moderate and high ongoing support.

DES limits job search assistance to two years but offers time-unlimited support for people at work.

anticipation of discrimination has been shown to deter two thirds of people with mental illness from applying for work

Assessment Process for JSA and DES

The level and type of support received by job seekers is based on results from the Job Seeker Classification Instrument (JSCI), an Employment Services Assessment (ESAt) and or Job Capacity Assessment (JCA). Previously JCA included assessments for both employment services referral and Disability Support Pension eligibility however since July 2011 this has been split between ESAt and JCA respectively (DEEWR 2013).

- The JSCI is used and conducted by Centrelink officers to stream relatively less disadvantaged job seekers. The assessment draws primarily on information disclosed by the job seeker, but can also make use of information gathered independently by Centrelink.
- The ESAt is used by health and allied health professionals to determine the type of employment services and assistance that are required by the most disadvantaged job seekers.
- The JCA is used by health and allied health professionals for the purposes of determining a person's medical eligibility for DSP. Unlike the ESAt, the JCA is not primarily employment services driven.
- The Department of Human Services (DHS) Assessment Services is responsible for conducting ESAt and JCAs.
- Entry to Stream 4 JSA is based on an Employment Services Assessment or Job Capacity Assessment.

The JSCI tries to ascertain whether a job seeker has complex barriers to employment that require further assessment through an ESAt in an attempt to find the most suitable service. The ESAt determines whether the job seeker can be best served by DES-DMS, DES-ESS, JSA streams one through four or be recommended to other programs like sheltered employment at an Australian Disability Enterprise (Department of Employment 2013). The ESAt can also assess the job seeker as being unable to benefit from employment services (Ibid.).

These ESAt also dictate how many hours a job seeker is expected to be able to achieve (hour employment benchmark) which has flow on effects for providers claiming outcome payments. There are employment benchmark bandwidths of 0-7 hours, 8-14 hours, 15-22 hours, 23-29 hours and 30 or more hours (Ibid.).

The section of the JSCI related to Disability/Medical Conditions is aimed at finding the relative labour market disadvantage faced by job seekers. The assessment allocates points to a job seeker based on their responses to a JSCI questionnaire which is complemented by

information ascertained through the ESAt or JCA (for DSP recipients). The higher someone's score on the JSCI the further they are assessed as being from the labour market. This supplementary information allows for automatic updating of a job seeker's JSCI, their work capacity and hourly benchmark. If someone declined to answer the questions on the JSCI they are assigned a one point score (DEEWR 2012).

The Work Capacity component overrides the Disability/Medical Condition component when a job seeker is assessed as being able to work less than 30 hours per week. This means zero points are allocated to the job seeker for the Disability/Medical Condition component

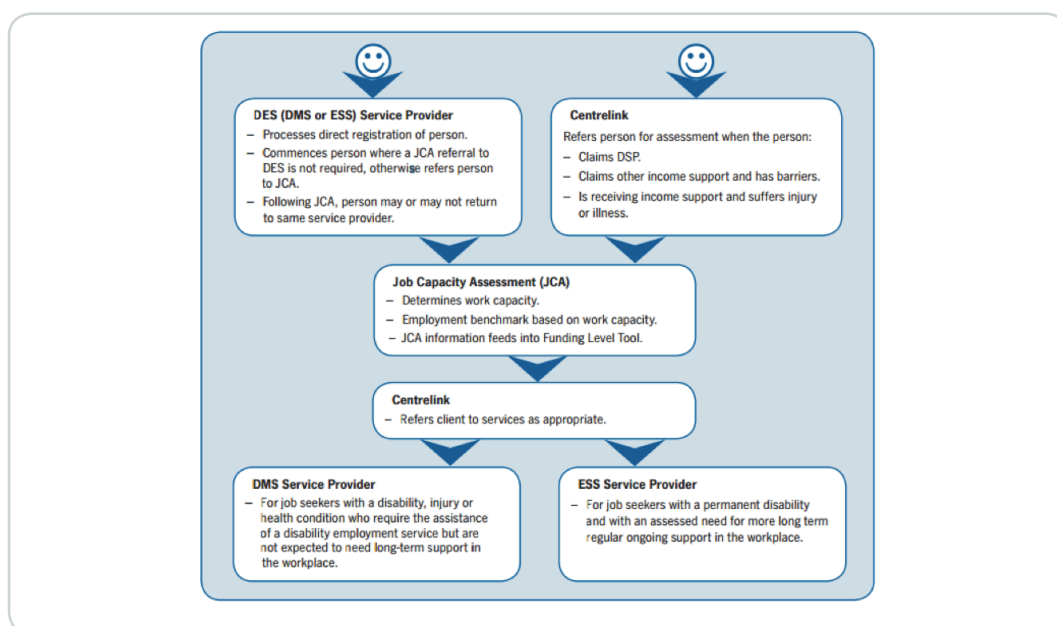


Figure 2: Pathways to DES (Reproduced from Evaluation of DES 2012 DEEWR)

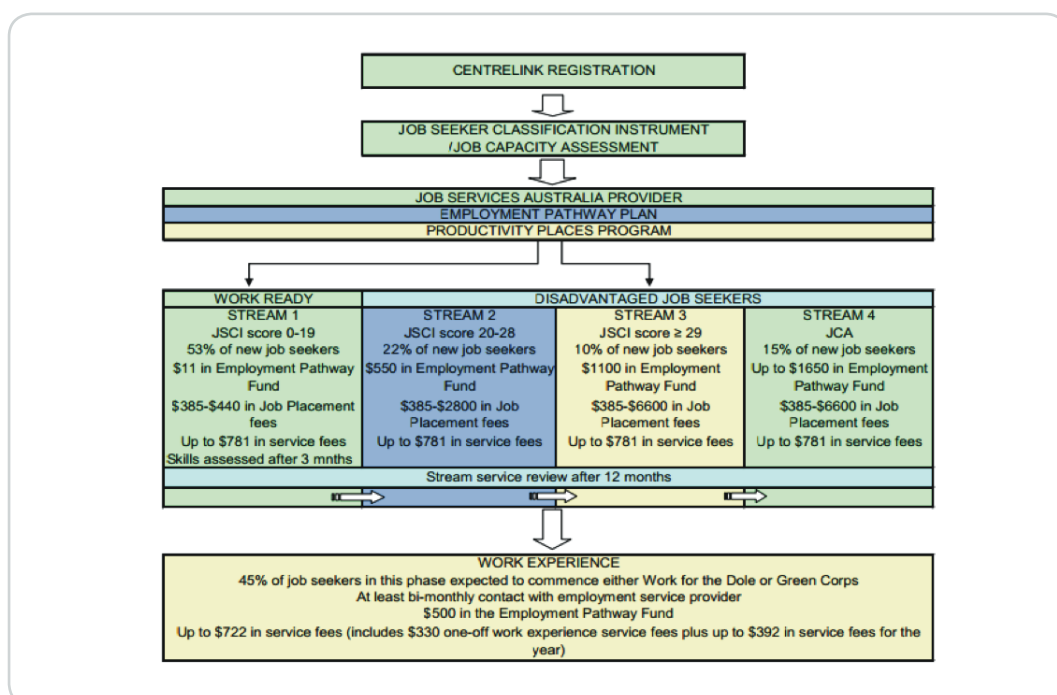


Figure 3: Reproduced from Evaluation Strategy for JSA DEEWR 2009

Funding Structures for JSA

JSA providers receive service fees, Employment Pathway Fund credits, funding for the work experience phase, payments for job placements as well as 13 and 26 week pathway and full-outcomes. These payments vary based on assessments of a job seeker's distance from the labour market or level of disadvantage as dictated by their stream of service.

For a complete description of all fees payable to JSA providers refer to the Deed.

Service fees	Stream one	Stream two	Stream three	Stream four
First 13 weeks	\$63	\$271	\$332	\$587
Second 13 weeks	\$414	\$208	\$264	\$512
Third 13 weeks	\$94	\$202	\$257	\$409
Fourth 13 weeks	\$96	\$204	\$267	\$411
Fifth 13 weeks	Na	Na	Na	\$402
Sixth 13 weeks	Na	Na	Na	\$415
Total	\$667	\$885	\$1120	\$2736

Work experience phase	Amount (\$)
First 13 weeks	\$456
Second 13 weeks	\$66
Third 13 weeks	\$133
Fourth 13 weeks	\$67

Compulsory activity phase	Amount (\$)
First 13 weeks	\$133
Second 13 weeks	\$66
Third 13 weeks	\$133
Fourth 13 weeks	\$67

Amount (\$)	Stream one	Stream two	Stream three	Stream four
Employment pathway fund	\$11	\$550	\$1100	\$1100 + \$550 after 12 months of unemployment in stream four
Early school leaver bonus to EPF	NA	\$500	\$500	\$500

Outcomes	Stream one	Stream two	Stream three	Stream four
Job placement fee	\$385-\$440	\$385-\$550	\$385-\$550	\$385-\$550
Full outcome	\$572-\$854	\$675-\$1400	\$1418-\$3300	\$1418-\$3300
Full outcome +bonus	\$686-\$1025	\$810-\$1680	\$1702-\$3960	\$1702-\$3960
Pathway outcome	\$252-\$376	\$446-\$550	\$446-\$1100	\$891-\$1100
Pathway outcome +bonus	\$302-\$451	\$535-\$660	\$535-\$1320	\$1069-\$1320

Funding Structures for DES

DES providers receive service fees, job placement fees, outcome payments, ongoing support fees and job in jeopardy payments.

There are a variety of different outcome payments in DES: a Job in Jeopardy Outcome, a Pathway outcome and a Full Outcome. A DES provider can only claim one of either the Pathway Outcome or Full Outcome payments in a single service period.

There is also a 52 week indicator which is an outcome measurement not attached to any additional funding. This is linked to performance.

Full outcomes refer to a variety of circumstances but of particular relevance for this report it refers to people placed in jobs for 13 or 26 weeks at or above the hourly employment benchmark as assessed by Centrelink. Full outcomes also refer to people aged 15-21 years old without a Year 12 or equivalent qualification who complete a semester of a course that is at least one year long.

Pathway outcomes require a job seeker to work two-thirds of their assessed capacity. Pathway outcomes also refer to a person aged between 15 and 21 years who finishes a semester of a course that is at least one

year long and meets the Qualifying Education Course requirements.

The provision of Job in Jeopardy assistance in the DES system is aimed to helping employees at risk of losing their job due to their disability or health condition. The DES provider can help the worker as soon as they present to the service working with the person and their employer to help the retention of employment. To receive a Job in Jeopardy Outcome someone must remain in employment for the normal amount of hours per week for 26 weeks after the date which they started receiving the assistance.

There are payments for ongoing support that depend on the level of intensity. Ongoing support can be provided in flexible, moderate and high settings.

There are also bonus payments for employment outcomes achieved that are related to training programs.

Providers can use money from the Employment Assistance Fund to help people experiencing problems as a result of their condition access specialist mental health services.

For a complete listing and description of fees paid to DES providers refer to the Deed.

Service fees	DMS	ESS Funding level 1	ESS Funding level 2
First 13 weeks	\$1,595	\$890	\$1,900
Second 13 weeks	\$1,595	\$890	\$1,900
Third to sixth 13 weeks Service fees	\$715	\$890	\$1,900
Extended assistance first and second 13 weeks	\$715	\$890	\$1,900
Total	\$7,480	\$7,120	\$15,200
Outcome payments	DMS	DES-ESS FL1	DES-ESS FL2
Job placement	\$770	\$770	\$1,540
13 week full outcome	\$2,860	\$2,860	\$5,500
26 week full outcome	\$4,400	\$4,400	\$7,700
13 week pathway	\$945	\$945	\$1,815
26 week pathway	\$1,450	\$1,450	\$2,540

Performance Evaluation and the Star Ratings system in DES and JSA

Contracts are tendered by the Department for JSA every three years and for DES every five years. Providers are referred clients based on their market share. This means a fixed share of business or referrals within Employment Services Area (ESA) is given to the employment service provider. The market share can be increased or decreased based on the provider's performance which is calculated using the Star Ratings system. A star rating of one, two or three means an employment service provider can have their business share reallocated to a higher performing service. The Department undertakes this review every 18 months and takes any extenuating circumstances into consideration during the reallocation.

Performance of service providers is assessed against a set of Key Performance Indicators around efficiency, effectiveness and quality. Efficiency is understood as the proportion of referrals to a provider that start in the employment services program and the time taken by providers to place job seekers in employment. The effectiveness KPI refers to the proportion of job seekers that achieve outcomes or in other words find work. The quality indicators are assessed against compliance with the Employment Services Deed and look at organisational health, types of services provided and client experiences.

The KPIs around efficiency and effectiveness inform the five-tier Star Ratings system. Each KPI is assessed through a number of separate performance measures which are combined using weightings chosen by the government into an overall assessment of performance. The Star Ratings system is then used to look at the relative performance of providers. Ratings are based on the percentage difference between each site's performance and the national performance average. Differences in labour market conditions and job seeker characteristics are taken into account using statistical regression. The system is designed to allow comparisons between providers.

Providers who receive a five-star rating are assessed as being 40% or more above the national average. Four-star providers are those who achieve performance 20% to less than 40% above the national average. Three-star providers achieve performance between 20% below the national average to less than 20% above the national average. Two-star providers are assessed as between 50% below and less than 20% below the national average. One-star providers are 50% or more below the national average.

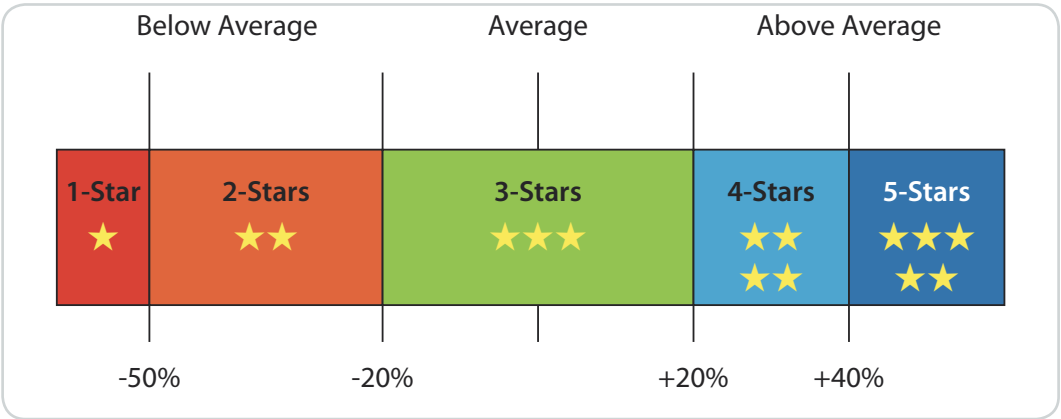


Figure 4: Distribution of star ratings (reproduced from DES star ratings methodology advice v1.1 Australian Government 2013)

Performance measures and Weightings for DES and JSA are different. The following tables will set out the measures and weightings for each of the programs.

JSA performance measures and weightings

Performance Measure	Weightings in JSA Star Ratings Model			
	Stream 4 40%	Stream 3 30%	Stream 2 20%	Stream 1 10%
13 Week Full Outcomes	20%	20%	20%	10%
13 Week Pathway Outcomes	10%	10%	10%	5%
13 Week Bonus Outcomes	15%	15%	15%	10%
Speed to 13 week Full Outcomes		5%	5%	
13 Week Outcomes Total	45%	50%	50%	25%
26 Week Full Outcomes	20%	30%	30%	10%
26 Week Pathway Outcomes	10%	10%	10%	5%
26 Week Outcomes Total	30%	40%	40%	15%
Barriers Serviced	15%			
Social Outcomes Total	15%			
Paid Placements	10%	10%	10%	30%
Speed to Job Placements				10%
Job Placements Total	10%	10%	10%	40%
Off Benefit				15%
Speed to Going Off Benefit				5%
Off Benefit Total				20%

Source: Job Services Australia Star Rating methodology From July 2012 to June 2015, Australian Government.

DES performance measures and weightings

	Performance Measure	DMS Weighting	ESS Weighting
2.1	Job Placements Proportion of participants who are placed into employment	5%	5%
2.2	13 Week Outcomes	35%	30%
2.2.1	13 Week Full Outcomes Proportion of participants who achieve a 13 Week Full Outcome	(25%)	(20%)
2.2.2	13 Week Pathway Outcomes Proportion of participants who achieve a 13 Week Pathway Outcome	(5%)	(5%)
2.2.3	13 Week Bonus Outcomes Proportion of relevant anchors that convert to a paid 13 Week Bonus Outcome or a 13 Week Full or Pathway Outcome for Indigenous participants	(5%)	(5%)
2.3	26 Week Outcomes	45%	40%
2.3.1	26 Week Full Outcomes Proportion of participants who achieve a 26 Week Full Outcome	(35%)	(30%)
2.3.2	26 Week Pathway Outcomes Proportion of participants who achieve a 26 Week Pathway Outcome	(5%)	(5%)
2.3.3	26 Week Bonus Outcomes Proportion of relevant anchors that convert to a paid 26 Week Bonus outcome or a 26 Week Full or Pathway Outcome for Indigenous participants	(5%)	(5%)
2.4	52 Week Sustainability Indicator/Job in Jeopardy Proportion of anchors for employment that convert into a 52 Week Sustainability Indicator and the proportion of JIJ anchors which convert to a JIJ outcome	10%	10%
2.5	Ongoing Support Proportion of ongoing support participants who remain in employment or exit ongoing support as an Independent Worker	5%	15%

Source: reproduced from DES star ratings methodology advice v1.1 Australian Government 2013

The Department of Employment is currently undertaking an evaluation of JSA. This will look at the current arrangements with a view to improving participation, effectiveness, efficiency and cost-effectiveness, and the evaluation will feed into the next tender for services in 2015.

DES providers have recently gone through a tendering process where one-, two- and three-star providers re-tendered for contracts. The next round of contract tendering will occur in 2018.

Employment policy implications and recommendations

This section sets out the performance of the various employment services for job seekers with mental illnesses. There are not separately reported outcomes

for young people with mental illness. The report then describes areas that could be changed to effect improvements in the outcomes achieved by people with mental illness. This section not only sets out changes to the employment services but also the Disability Support Pension in order to encourage more people with mental illness back into the workforce.

Results in the Job Services Australia system

There are around 700,000 unemployed Australians at any given time. Almost a third are unemployed for more than two years (DEEWR 2012-13). The 2012-13 DEEWR annual report shows that 22.6% of stream four job seekers were employed after three months in the JSA system and a further 20.2% of job seekers in stream four were in an education or training program (Ibid.). Each employment outcome in stream four JSA represented a cost of \$7,539 (Ibid.). However, despite the employment services system helping to place more than 1.6 million

people into jobs since 2009 (Ibid.) fewer than 20% of the most disadvantaged job seekers have found employment that has lasted 26 weeks through JSA (Jobs Australia 2013).

Data on the number of people with mental illness and the outcomes they achieve in the JSA system are not publicly reported which is problematic in analysing effects on this cohort, even more so when trying to specifically understand the situation facing young people with mental illness.

A 2010 report by the Mental Illness Fellowship of Australia stated that “However the efficacy of Australian employment assistance services for people with mental illness remains largely unknown due to multiple disconnected programs and fragmented data collection. Currently in Australia evaluation of specialised employment assistance is ad hoc and it is difficult to identify the effective programs, or the effective elements of programs that can lead to improved service development.” (Mental Illness Fellowship 2010 p8).

However, the latest report on JSA released in September 2013 does give us an idea of the effectiveness of the system for all people with disabilities. These are job seekers who either through their Job Seeker Classification Instrument (JSCI) or Employment Services Assessment (ESAt) were determined to have a disability or medical condition or who were in receipt of DSP when they commenced their phase of assistance.

In the year ending September 2013, 32.7% of job seekers with a disability gained employment (8.5% full-time and 24.2% part-time) three months following participation in JSA, compared with 42.8 per cent of all job seekers. Participation in education and training for job seekers with disability was also lower at 18.7 per cent compared to 22.7 per cent for all job seekers (Department of Employment 2013). The results for each stream in the year ending September 2013 three months following participation in JSA were as follows (Department of Employment 2013):

- 22.8% of stream 1 participants with a disability achieved full-time employment, 29.3% part-time, 18.9% education & training and 8.8% were no longer in the labour force.
- 9.9% of stream 2 participants with a disability achieved full-time employment, 28.3% part-time,

19.8% education and training and 19.2% were not in the labour force

- 5% of stream 3 participants with a disability achieved full-time employment, 28.2% part-time, 18.8% education & training and 19.2% were not in the labour force
- 6.3% of stream 4 participants were employed full-time, 17.4% part-time, 18.1% education & training and 34.6% were not in the labour force

The results for disabled job seekers are not surprising given they require more intense individual support from employment services and caseloads for JSA in 2012 were reported to average 114 per employment consultant (Davidson 2013).

Results in the Disability Employment System

DES has recorded 170,000 job placements since March 2010 (DEEWR 2012-13). The stated target population of DES is “people who receive Disability Support Pension (DSP) plus people with disability who are in receipt of Newstart Allowance or Youth Allowance” (DEEWR 2012 p19). DEEWR’s evaluation report released in 2012 stated that approximately 8.8% of the target population were using services in December 2010 up from 7.7% a year earlier (Ibid.).

Limiting the target population to people in receipt of the DSP allows for an analysis of people using DES by disability type. Among DSP recipients, participation in the programs for people with psychiatric disability (3.5%) is lower than learning or intellectual disabilities (8-10%) but higher than physical disabilities (1.8%) (Ibid.).

The DES evaluation report released in March 2012 looking at outcomes from March to December 2010 shows that of the 4,001 people with a psychiatric disability enrolled in the DMS program only 26.6% (1,066) were placed

in a job and only 14.2% (568) reached the 13 week outcome (Ibid.). The figures are even worse for the DES-ESS programs. For DES-ESS funding level one 2,831 people with a mental illness were enrolled of which 24.2% (686) found a job and 14.2% (402) reached the

Data on the number of people with mental illness and the outcomes they achieve in the JSA system are not publicly reported which is problematic in analysing effects on this cohort, even more so when trying to specifically understand the situation facing young people with mental illness.

The star ratings system also allows for the performance of all providers to decline, drifting toward lower outcomes, while maintaining relative performance and their star rating

13-week outcome. There were 1,333 people with a psychiatric disability enrolled in DES-ESS funding level two of which 18.8% (251) were placed in employment and 10.6% (141) were still there after 13 weeks (Ibid.).

This compares poorly to the overall performance of DES as reported in DEEWR's 2011-12 annual report. The report says that 40.8% of people in DES-DMS were employed three months after participating in the employment service and 36% of people in DES-ESS (DEEWR 2011-12).

While data on caseload levels for DES providers is not publicly available, anecdotal reports indicate average levels of around 40-50 job seekers per employment specialist. This could be hampering services given these job seekers require intensive individual support. Write, Marston and McDonald said in a 2011 paper that "the demand for service, expressed in terms of large caseloads, works against the possibility of establishing ongoing rapport and tailored, individualized service delivery for clients. In short, the competencies of traditional human service case management are not conducive to the output imperative demands of the system" (Write, Marston & McDonald 2011 p313). A report produced by the Department of Education, Employment and Workplace relations in 2007 found increasing client-to-staff ratios was linked to lower employment rates (DEEWR 2007).

In addition, current participation and unemployment rates for people with mental illness illustrate that despite recent changes to employment services in Australia and an increase in spending on mental health programs, the majority of people suffering from psychiatric disorders are being excluded from the employment market.

Recommendation

In order to better target interventions, data on outcomes by age and disability type should be made publicly available.

Star Ratings

The star rating system is used to assess relative performance of JSA and DES providers. It uses statistical regression to create homogeneous cohorts for comparison, taking into account variables such as disability type and labour market conditions. While this is a useful tool in comparing employment service providers against each other it means that understanding differences in outcomes for different cohorts or disability groups is hindered. It is not comparing like for like outcomes in terms of hard-to-place job seekers with mental illness in one service compared to the same cohort in another service. The approach is too opaque meaning there is not enough transparency to connect provider action with employment outcomes.

The relative nature of star ratings also creates competition between providers to be better than each other rather than competition to reach expected absolute standards. As Considine says in his 2003 report this means that "in an environment of secrecy and with only one purchaser to please, contractors lack incentives to communicate good practice to others, including to the contractor" (Considine 2003 p75).

The star ratings system also allows for the performance of all providers to decline, drifting toward lower outcomes, while maintaining relative performance and their star rating (Waghorn 2011). Interestingly according to a 2007 SACES report, 95.1% of the differences in 26 week outcomes are not explained by client or labour market characteristics (SACES 2007). This means that the statistical regression used in the star ratings system to take into account client and labour market characteristics only accounts for 4.9% of the variance in 26 week employment outcomes which is in line with international evidence that client characteristics are not predictive of outcomes (Waghorn 2011).

Recommendation

In order to remove perversities created by the current star rating system, the Government should:

- Introduce absolute benchmarks for different disability groups based on historical data with annual reviews.

Employment Services Funding Structure

The payment structure for DES contains perverse incentives to over inflate caseloads and park the most difficult to place job seekers. This disadvantage is of particular importance to people facing the most severe barriers to employment such as those suffering mental illness who require the most intense individual support. While improvements have been made and outcome payments exist in both systems, the level of service fees means service providers can be financially sustainable in terms of hard to place job seekers without finding them work.

In JSA the most a provider receives from the four service fees in stream one is \$581, in stream two, \$885, in stream three \$1120 and in stream four \$2736 (Department of Employment 2012).

However, the four service fees attached to each job seeker in DES-ESS Funding level two amount to \$11,400 over 18 months without any need for the provider to find the job seeker any employment. The additional two service fees available under the extended employment assistance provision bring that total to \$15,200 (DEEWR 2013). There is \$14,740 available to DES providers for the same job seeker in terms of the job placement fee, 13 and 26 week outcome payments (Ibid.). A DES provider gets more money for keeping someone on the books for two years without finding them a job than for quickly achieving employment outcomes. A caseload of 50 ESS funding level two clients over two years generates more than \$750,000 in service fees alone which represents more than five times the two year salary of one full-time employment consultant (Waghorn 2011). While outcome payments help to offset rational profit maximising, the current setup fails to address rational profit maximisation motivation provided to over-inflate caseloads and park the hardest to place job seekers.

The justification for service fees is twofold. Firstly, the payments provide an impetus for providers to stay in regular contact with job seekers and secondly, the funding allows for the provision of resources for clients. While these are important factors in the provision of employment services, paying providers to stay in contact with clients is like paying a shopkeeper for staying in touch with her customers. In a high quality employment service, this should be happening anyway. This creates a perverse incentive to increase caseloads to unsustainable levels and park the most disadvantaged job seekers because funding is available for up to two years per client even if outcomes are not achieved.

Recommendations

Remove perverse incentives to overinflate caseloads and park or set aside the most disadvantaged job seekers by:

- Abolishing service fees and moving funding to outcome payments.
- Including quality of service and regular contact requirements in performance evaluation.
- Allow employment service providers credits or a portion of their funding based on their expected levels of job placements, 13 week, 26 week and 52 week outcomes. Any difference in expected outcomes and the actual outcomes achieved could then be recouped at the end of the financial year.
- Provide service fee funding on the basis that it must be spent on the job seeker and not within the employment service.

In order to improve incentives to providing quality services:

- Attach an outcome payment to the 52 week outcome indicator. This would promote long term employment options and incentivise employment service providers to seek sustainable work options.
- Introduce 65 week outcome payment.
- Investigate possible contract requirements to limit active caseload size to 25 job seekers per employment specialist.

Full outcomes vs Pathway outcomes

One structural issue in DES is the fact that providers can only claim payment for one 13 and 26 week outcome (DEEWR 2013). This is important as the Pathway outcome aimed toward educational achievement pays a lower fee than the full-outcome. There is therefore a disincentive for a rational profit maximising actor to seek anything but a full-outcome. While employment in the competitive labour market is rightly the aim of employment services the effects on young job seekers with low educational attainment warrants closer examination. Low levels of educational attainment amongst people suffering mental illness are worrying and have long term career implications as illustrated earlier in this report. This is particularly important for young job seekers in the DES system.

Recommendation

- Allow employment service providers to claim both a pathway outcome and full-outcome for young job seekers suffering mental illness who have low levels of education. This could be done on a pro-rata basis. If the job seeker achieves an employment outcome after a pathway outcome then the difference in the fees could be paid to DES providers.

Ongoing support

The provision of ongoing support in DES is essential for job seekers who face significant difficulty maintaining employment. However, its inclusion in the performance evaluation creates a perverse incentive to not offer ongoing support to people who most need it. This occurs when a provider knows the client is at risk of losing their job and instead of intervening as strongly as possible there is an incentive in order to maximise the performance measure to exit the DES participant.

Instead of using the proportion of successful ongoing support clients in the performance evaluation the Department could move to a slightly different model. The number of successful ongoing support participants could be used as a bonus factor in performance evaluation. This would remove the perverse incentive that currently exists to remove job seekers at risk of losing their job and in need of ongoing support and replace it with an incentive to provide these riskier DES participants support when they need it most.

Recommendations

Two options for removing the disincentive to offer ongoing support to job seekers most in need:

- Eliminate the perverse incentive to remove job seekers at risk of losing their job and in need of ongoing support by using the number of successful ongoing support participants as a bonus factor in performance evaluation instead of the proportion of successful ongoing support outcomes.
- Remove ongoing support as a measure that affects star ratings and simply reward ongoing support outcomes with current funding arrangements.

Assessment processes and classification

The classification process is another area that has improved due to recent reforms but is still problematic. There appears to be a lack of attention devoted to the effects of mental illness in the assessment process. According to the 2012 DES evaluation report 81.3 per cent of newly referred job seekers with a recommendation for DES DMS commenced in DMS and 74.2 per cent with a recommendation for DES ESS commenced in ESS (DEEWR 2012). This compares favourably to the previous iterations of disability employment services VRS (74.9%) and DEN (58.4%) (Ibid.). However, the second National Survey of Psychosis found that among those looking for work only 30.5% of people with psychotic disorders were using DES. 32.1% of people with psychosis were receiving help from Job Services Australia (Waghorn et al 2012). This is worrying because a job seeker cannot receive assistance from both DES and JSA at the same time and does not choose the type of assistance they receive. This means that "the mandatory national job capacity assessment system may be misclassifying up to 30% of people with psychotic disorders, by underestimating their assistance needs" (Waghorn et al 2012, p782).

This would seem to reinforce a goal outlined in the DES 2012 evaluation report which stated participants would benefit from "increased use of specialist assessments where indicated, particularly for job seekers with suspected undiagnosed mental illness; this would require a review of existing policy and possible significant budget implications" (DEEWR 2012 p xviii). The same report also indicated improvements to the JCA are needed to better encapsulate the support needs required by job seekers (Ibid.).

One example that could be used to improve assessment of psychiatric conditions is the Personal and Social Performance (PSP) scale. This is a 100-point rating scale based on assessment of a person's function in four areas:

- Socially useful activities
- Personal and social relationships
- Self-care
- Disturbing and aggressive behaviours

Morosini et al developed the scale and found it to be a good, fast, valid measure of patient's personal and social functioning (Morosini et al 2000; Brissos et al 2011). Each question is rated on a six point severity scale with the interviewer assigning a global functioning score based on the interview in the four areas and any additional information gained. The system allows for tracking of functioning in the four domains over time and in various phases of the illness which is particularly useful due to the episodic nature of mental illness. It has been used in randomised controlled trials, validated in several countries in both acute and stabilised patients showing reliability and sensitivity to long term changes in illness severity (Brissos et al 2011).

Recommendations

- Introduce a scale such as the PSP for assessment of mental health conditions to better capture the needs of this cohort of job seekers.
- Streamline assessment procedures for people with mental illness already on the DSP. This category of people should be encouraged to access employment services through the DES system and should not be allocated a prescribed hourly benchmark or face lengthy delays caused by assessment procedures that cause a loss of motivation. Any amount of work should be seen as a positive outcome in their journey to recovery.

Administration leading to standardisation

The administrative burden under DES has not been improved by recent reforms. The majority of DES providers (79%) believe there is a higher administrative burden under the new system (DEEWR 2012). According to the National Employment Services Association (NESA), providers' frontline staff spend around half of their time on administration (NESA 2013).

The high administrative burden is often reported by employment service providers as problematic. Changes to program settings can lead to DES providers having to focus more on compliance to avoid breaches of contract. In the two years before 2012 there had been a total of eight different guidelines released including 12 policy changes and ten clarifications. This represents a fraction of the 41 other sets of guidelines for DES providers. This snapshot illustrates the administrative and compliance burden placed on service providers.

The performance framework and service provider contracts have caused service standardisation in an attempt to minimise risk. A study by Considine et al in 2011 based on changes observed in survey data from 1998 and 2008 illustrated that "between the two studies there was a marked increase in the level of routinisation and standardisation on the front line.

This suggests that the sector did not achieve the enhanced levels of flexibility so often identified as a desirable outcome of reform" (Considine et al 2011). As employment services have matured DEEWR, until recently the purchaser of Australian employment services, required providers to enter into more detailed contracts "which had the dual effect of reducing flexibility and eroding diversity between agencies" (Ibid.). Efforts by the department to increase contract compliance and punish providers through the refunding of fees and the reallocation of business share engendered fear and produced a greater push from providers to reduce risk through forms of service standardisation (Ibid.).

During the 2008 Australian Government review of employment services submissions from peak employment service bodies NESA and Jobs Australia raised objections to the prescriptive and innovation-stifling practices (Commonwealth of Australia 2008).

As Bredgaard and Larsen put it "the general impression is that, in spite of freedom to choose their own methods, providers hardly ever come up with innovative solutions. Rather than developing new methods and innovating services, the providers' primary focus is on survival, and they are not willing to take any risks unless the outcome is considered certain" (Bredgaard & Larsen 2008 p345).

A DES provider gets more money for keeping someone on the books for two years without finding them a job than for quickly achieving employment outcomes

In response to the problems raised by NESA and Jobs Australia the Australian Government stated employment services need flexibility and resources to help the most disadvantaged job seekers (Commonwealth of Australia 2008).

However, given the administrative burden has been reported by service providers to have increased since this review there is a logical probability that employment service providers will continue to try and mitigate risk and in doing so limit innovation. As Considine et al put it, "what neither quasi-markets nor tight regulations succeed in doing on their own was to promote innovative solutions for the most vulnerable" (Considine et al 2011). This is particularly important for groups of job seekers such as those suffering mental illness who are disadvantaged by the current setup.

Disability Support Pension

The Commonwealth has looked at the disincentives to employment for people on the Disability Support Pension (DSP) that included (DEWR 2004):

Anticipated difficulty re-establishing entitlement to DSP

- Lack of knowledge of DSP suspension arrangements
- Lack of knowledge of earnings credits and applicable income tests
- Lack of knowledge of assistance available to obtain employment

Introducing a system that provides a safety net once people have been proved eligible creates both an incentive to work because you can earn more money

and gets rid of the disincentive that currently exists around returning to work regarding loss of access to benefits. While it is rarely the case that a person will be worse off when working on the DSP, widely held perceptions and fear create disincentives to even try and return to work.

It is clear people with mental illness can be easily discouraged from trying to return to work. Setting up a system that supports and encourages people back into the workforce could help overcome these barriers.

Recommendations

- Provide high quality IPS services based in mental health services for young people in an effort to prevent a perceived need to access DSP in the first place.
- Require people with mental illness under the age of 25 to return to Centrelink once every three months to determine whether Disability Employment Services could help. This should not affect DSP eligibility. Instead it involves checking to see how the episodic impairment is progressing and if vocational rehabilitation should be considered as an option.
- Once a person has been deemed eligible for the DSP they should be able to return quickly to payments if they have tried to return to work and their condition has deteriorated. This means that a person who tries to work when on the DSP succeeds in finding a job and has their payment reduced to zero can rely on a safety net if their disability or illness gets worse.
- Introduce independent benefits counselling. In order to counter perceptions that working while on the DSP will leave the person worse off more information must be provided.

Section 4: Evidence-based employment interventions

This section of the report will set out possible alternatives to current employment services. Firstly by describing some characteristics of best practice according to the OECD then describing each model and finally by looking at research around employment outcomes for each model. The paper will then set out recommendations to improve the quality of and access to employment services.

Best Practice in Employment Services According to the OECD

The OECD launched a review in 2006 looking into policies that promote Jobs for Youth in 16 countries including Australia. Completed in 2009, the review identified the following features of 'best practice' in public employment services to facilitate the transition from school to work and improve the career prospects of youth.

- Early intervention. Programs should begin as early as possible to avoid lock-in effects of long term unemployment.
- Job search assistance. The report found that the most cost effective programs for young people are job search assistance programs. Wage and employment subsidy programs were found to have positive short-term impacts but were less positive long-term in regards to employment prospects.
- Connecting training programs to local and national labour markets requires private sector and local community involvement in project design.
- Targeting programs. Making sure that teenagers are helped with educational attainment while young adults are given opportunities to boost their work history.
- Focus on school dropouts.
- Integration of services into a comprehensive package is essential to best practice.
- Tight job search requirements.

Social Firms

Social Firms are a type of business or enterprise that employ people who face disadvantage in the open labour market due to their disability. These companies produce goods and services in competitive markets to pursue their social mission (Svanberg et al 2010; Williams et al 2012). People who are not disabled can work in these businesses but the purpose of social firms is to provide paid work to people with a disability as well as other disadvantaged job seekers. Social firms empower disadvantaged individuals and promote the physical, social and mental health of their members (Svanberg et al 2010). Through integration in the wider community, an understanding environment of mental illness and the provision of meaningful activities, employees can overcome barriers and discrimination faced in mainstream work settings (Secker et al 2003).

A study of two social firms in Scotland found that the feeling of inclusion encouraged in the businesses was beneficial to people with mental illness (Svanberg et al 2010). Having somewhere to go and activities with a visible purpose was beneficial not only because it acted as a distraction from symptoms but also due to the valuable social and vocational skills gained (Ibid.). Recovery was also aided by interactions in accepting social groups, a sense of belonging and added purpose (Ibid.). Providing an environment in which participants were more than just their mental illness facilitated a shift in self-concept and helped develop a sense of a hopeful future where the attainment of life goals despite ongoing symptoms was achievable (Ibid.).

A study looking at a social firm in Australia had similar findings (Williams et al 2012). Workplace features such

as pay, workplace conditions, job security, achievable but challenging tasks and a flexible work environment were found to be strongly supportive for people with mental illness (Ibid.). The report found three guiding principles for the development of supportive social firms. The three principles are: the provision of permanent jobs with statutory minimum awards and conditions; designing jobs to be regular, flexible & promote feelings of competence; and a naturally supportive social environment (Ibid.).

A Norwegian study found that social firms increase employability and subsequent job retention offering a helping hand to people who have been excluded from the labour market for significant periods or face large barriers to employment (Lysaght et al 2012). While few social firms are able to operate without some subsidies or external financial support there is potential for a reduction in the burden on taxpayers because social firms can act as an alternative type of rehabilitation service (Ibid.). There are also arguments that social firms segregate disabled people from the local community however there is something to be said about the flexible and supportive work environments as an avenue for marginalised groups (Ibid.).

Research from the UK suggests social firms are stable forms of employment for people with mental illness, which was illustrated by an average job retention of two years (Gilbert et al 2013). The study found absences due to sickness in social firms were around 8 days a year per employee compared to the UK average of 4.5 days (Ibid.). The report also found employers generally had an understanding of workers' conditions and liaised with mental health services meaning they were able to provide better levels of support and allay fears of clinicians that work could be harmful to their patients recovery (Ibid.). Another benefit could be seen in the greater ability of social firms to overcome barriers such as stigma and pressures of working while coping with mental illness due to the embedded ethos (Ibid.).

In Australia Supported Employment services provide employment within a commercial enterprise. This encapsulates Australian Disability Enterprises, which are similar to social firms. They target people with a disability who are unlikely to be able to work in the open employment market. They help people with a disability to take part in paid employment, develop capabilities and promote socialisation through activity in community life (FAHCSIA 2008). The Australian

Government Disability Services Census 2008 reported there were 413 supported employment services (Ibid.). There were 22,167 people using supported employment services in 2007-08 of which 11.7% (2,585) had a psychiatric disability (Ibid.). A further 806 people had a psychiatric condition in addition to their primary disability (Ibid.). People with a psychiatric disability had the lowest employment outcomes at 92.1% (Ibid.).

There are five phases for people enrolled in a supported employment service; worker, work experience, job seeker, independent worker and other. (Ibid.) A worker is someone who has accepted a contract in a supported employment service. Someone in the work experience phase is undertaking paid or unpaid work experience or a trial at a supported employment service. A job seeker is a person receiving assistance from a supported employment provider to prepare or help place them in work. An independent worker is person assisted by a supported employment service to get a job who the following year receives no further help from the employment service. Other refers to a person engaged in non-vocational activities in a supported employment service (Ibid.).

Clubhouse Model

There are over 300 clubhouses worldwide and eight in Australia (ICCD 2013). These centres provide services to people with severe mental illness and are based on the model developed by a group of ex-patients who started the first clubhouse called Fountain House in 1948. There are 36 accreditation standards guided by four principles:

- A right to a place to come
- A right to meaningful work
- A right to meaningful relationships
- A right to a place to return

Clubhouses rely on both government and philanthropic funding and are run as independent centres linked to Fountain House via tri annual accreditation fees (Raeburn et al 2013). They offer a broad range of rehabilitation activities such as case management, social advocacy, housing assistance, psycho educational and employment programs. These services are aimed at increasing confidence and empowering people through supportive relationships (Ibid.).

The model's pre-vocational program is called "the work ordered day" which places members alongside paid staff in an attempt to build skills through helping with reception and administration, meal preparation and building maintenance activities (Ibid.). Through working in this typical business day in a rehabilitative environment, members can build confidence and a sense of capability (McKay et al 2005).

Another vocational program is called the transitional employment program (TEP). These positions act as a stepping stone towards paid employment in the open labour market and are organised between clubhouses and local businesses (Raeburn et al 2013). These jobs are offered for a limited duration and are designed to be part-time (McKay et al 2005). Members also have the opportunity to undertake transitional employment positions without work experience (Ibid.).

The third vocational offering is called the supported employment program (SEP). Clubhouses offer ongoing assistance to find, get and keep jobs in the competitive employment market through both onsite and offsite supports upon the member's request (Raeburn et al 2013; McKay et al 2005). Members may have to go through an interview process because these jobs are not linked or "owned" by the clubhouses and unlike the TEP employers select the employee (McKay et al 2005).

People also have the opportunity to partake in independent employment (IE). These positions require members to go through a fully competitive interview process. IE is characterised by the lack of a relationship between clubhouses and employers and the absence of onsite supports (Ibid.).

Criticisms of the model revolve around two areas, namely a lack of consistent access to psychiatric treatment and institutional dependence (Raeburn et al 2013; Crowther et al 2001). This concern around the reliance of members on the Clubhouses revolves around the possibility of compromising members' ability to move toward paid employment. However, the provision of a safe environment, social networks and employment opportunities are valuable for people suffering mental illness (Raeburn et al 2013).

McKay et al conducted a study looking at employment outcomes across the TEP, SEP and IE in 17 clubhouses in Massachusetts between 1998 and 2001 (McKay et al 2005). The study found that 1,702 members were

employed in 2,713 separate job placements over the three year period (Ibid.). This included 1,107 placements in transitional employment, 730 SE and 877 in IE. The mean time to job in this study was 6.4 months and mean hours worked were 13.87 hours/week for TE, 18.3 hours/week in SE and 21.1 hours/week in IE (Ibid.). Employed members average clubhouse affiliation was 6.45 years (Ibid.). However, the study failed to report movement across job types and impacts on employment outcomes of the various programs.

A further study examined 138 clubhouse members and their progression from transitional employment to competitive employment (Henry et al 2001). It found that average tenure in TE was unrelated to the severity of disability and 30.4% (42) of members obtained competitive employment in the one year following their work transitional employment program (Ibid.). The report also indicates a link between total hours employed in TE and an increased probability of obtaining competitive employment (Ibid.). The study also found that rapid placement into TE and a better prior work history are factors important to predicting competitive employment outcomes (Ibid.). While this study looked at data from the early 1990s, its findings are still pertinent.

Individual Placement Support

Individual Placement Support (IPS) is an evidence-based employment services model for people with mental illness developed in the US (Drake et al 2012). The model has eight core principles:

- 1. Competitive employment.** This principle describes the main aim of IPS. Job seekers are helped to find employment in the open labour market. Employment specialists do not help in finding sheltered employment, unpaid internships or jobs set aside for people with mental illness so often associated with the stepwise approach which has dominated the vocational rehabilitation sphere. This is because these approaches have demonstrated to not be effective in leading to competitive employment in the short or long term (Drake et al 2012). There is also evidence that competitive employment can have positive effects in other areas of people's lives (Ibid.).
- 2. Eligibility based on client choice.** No job seekers are excluded on the basis of job readiness, diagnoses, severity of disability, symptoms, substance abuse or legal system involvement (Ibid.). The basis of involvement in an IPS service is based on desire to

work in a competitive job. Providers encourage clients to consider work as a possibility and talk about work possibilities during intake, treatment planning and mental health assessments. Opportunities are also provided to share stories of returning to work with other job seekers and people with mental illness in treatment groups and newsletters. Research has shown that screening for who can work through standardised assessments and assumptions by clinicians about patients who will not benefit from work are largely ineffective (Ibid.).

3. Integration of employment services and mental health services.

This means IPS providers and mental health treatment teams are not only colocated but are closely integrated and work collaboratively. Employment specialists attend treatment team meetings and share ideas and information to develop ways to improve client functioning and recoveries (Ibid.). This has been difficult in many current IPS settings but the evidence of the increased effectiveness of employment services that are integrated in clinical treatment teams is well documented (Ibid.).

4. Attention to Client Preferences.

Job searches are based on individual client preferences rather than employment provider judgements (Ibid.). Job searches are based on what the client wants, their strengths and work experiences. Job seekers list their employment history and identify characteristics they liked about previous positions. Clients also decide on work settings, wages and hours. Employment specialists provide suggestions to expand options and discuss the advantages and disadvantages of disclosing their illness to the prospective employers. Job seekers also determine whether employment specialists will be in direct contact with employers and discuss the types of supports they require. This aids in job retention and is based in a significant amount of literature that illustrates a connection satisfaction, longevity and client choice (Ibid.).

5. Personalised benefits counselling.

Employment specialists provide or help find accurate and understandable information about the effects work will have on the job seeker's welfare payments (Ibid.). While fear of losing benefits is a significant barrier for people with mental illness seeking employment, most people on benefits will actually be better off financially if they return to work. However, a lack of understanding of the effects of wages and hours worked on pensions and support payments creates

common misconceptions and fear around returning to the labour market.

6. Rapid job search. IPS providers start looking for employment opportunities immediately and help job seekers find work as soon as possible rather than providing lengthy assessments, training and counselling (Ibid.). Employment specialists work with clients in the first session to develop an employment plan and career profile based on client preferences, past experiences, skills, strengths, career goals and education. Face to face contacts with employers begin within the first month of the program. This helps maintain motivation and consolidates the feeling that employment specialists are working hard to achieve what the job seeker wants. It also helps to reinforce the job seeker's self confidence as employment specialist demonstrates their belief the person has skills. This does not refer to rapid placement in employment but rather the process of looking for work. Finding and placing job seekers in the first available job will often lead to a poor job fit and decrease job retention.

7. Systematic job development. IPS providers must build employer networks and relationships through systematic contacts. This is more than calling businesses looking for openings. It refers to creating relationships with employers by understanding the business and human resources. Future contacts revolve around discussions of possible employees when good job matches arise. There is evidence that poor skills in this area are very detrimental to the effectiveness of any employment service. This is important as people suffering mental illnesses often get discouraged and give up on self-directed job searches (Ibid.).

8. Time unlimited and individualised support. This means that job seekers can continue to receive support for as long as they require. IPS providers continue ongoing supports long after employment is found. Frequent contacts between employment specialists and clients are important even once in work to help with any required training and difficulties faced in the new environment. Once a person has held a job for a year then the employment specialist can discuss transitioning the client to another team member and off employment services. The developers of IPS argue that within the psychiatric rehabilitation sphere there has long been an understanding that artificial deadlines created through funding arrangements are counterproductive to long term work sustainability (Ibid.).

Evaluating the quality of IPS services

There is a 25-point fidelity scale that measures the quality of IPS services and research has shown services that achieve high scores produce better competitive employment outcomes (Bond et al 2012). Each item on the scale is rated from one to five with response alternatives linked to measureable elements of practice. There are three areas examined; staffing, organisation and services. The staffing section asks questions about caseload size, role of employment specialist and the services they provide. The organisation section assesses the integration of the service, contacts with clinicians, number and structure of employment specialists, the role of employment supervisor, zero exclusion criteria, the focus on competitive employment and executive team support. The services section looks at benefits counselling, disclosing disability information to employers, ongoing vocational assessments, rapid job search, individualised job search, job development, job types, ongoing support, time spent in and out of the office providing service and contacts with job seekers. The total for each section is added together with services scoring exemplary fidelity (115-125), good fidelity (100-114), fair fidelity (74-99) or not supported employment (0-73).

A recent Australian study looked at four IPS sites in regional New South Wales and found job seekers in the evidence-based employment model had three and a half times the odds of achieving 13 weeks employment than the people using DES (Waghorn et al In Press). Over nine months 45 out of 95 people (47.5%) started working, which compared to the national benchmark of 24.5% over the same period (Ibid.).

Another Australian study looked at the effectiveness of IPS as compared to treatment as usual for 41 people with first-episode psychosis (Killackey et al 2008). The results are compelling as 13 of 20 people receiving IPS found work compared with two out of 21 in the treatment as usual (TAU) group who were referred to external employment agencies (Ibid.). A further four people in each group enrolled in education bringing the success rate for the vocational intervention group to

85% (Ibid.). The 13 people in the intervention group also worked more hours per week (mean 33.9) compared to the TAU (mean 22.5) (Ibid.).

According to another study that looked at an IPS service in New Zealand outcomes for people with psychiatric disabilities can be greatly improved. The research reported 47% of 135 people found employment and 21% achieved educational outcomes (Porretous & Waghorn 2009).

Randomised controlled trials across the world have compared IPS (place and train) against the best available alternative vocational models (train and place) and found fidelity to the model leads to much improved outcomes among people with a mental illness. Across the studies those with higher fidelity achieved average outcomes of 61% gaining competitive employment compared to an average of 23% in sites using a train and place model (Bond, Drake & Becker 2008). Jobs found through IPS lasted an average of 24 weeks and were obtained around 10 weeks before the control groups (Ibid.).

In fact successful implementations of this evidence-based employment service for people with mental illness has now been documented in the USA (Bond et al 2001), the UK and Europe (Burns et al 2007), Canada (Latimer et al 2006), Hong Kong (Tsang et al 2009), Australia (Waghorn et al 2007; Killackey et al 2008) and in New Zealand (Porteous & Waghorn 2009). The Individual Placement Support model for vocational services has even been recommended for implementation by the House of Representatives Standing Committee on Education and Employment (Commonwealth of Australia 2012).

Additionally, IPS has also been adapted to education (Killackey et al submitted). In this small Australian study 18 out of 19 young people with a mental illness successfully returned to education through an IPS program. While preliminary data, the strong suggestion of these results is that IPS may be a very potent intervention when directed exclusively at education for young people with mental illness.

The Individual Placement Support model for vocational services has even been recommended for implementation by the House of Representatives Standing Committee on Education and Employment

Integrating publicly funded mental health services with employment services is a barrier to implementing the evidence-based IPS model. This is partially due to the governance of the separate services and partially due to organisational culture. Each State and Territory is

A study from the USA suggested that due to reductions in welfare payments, increased taxes, and decreased use of public health services, the implementation of evidence based IPS supported employment for people with mental illness could be achieved at little or no cost to government

responsible for mental health services but employment services are run by private organisations contracted to the federal government. There can also be push back from clinical teams not used to working in collaboration with employment service providers. The importance of integration can be seen in a 2009 study which reported employment outcomes of 60.3% over five months for an integrated service and 40% for a non-integrated service (Porteous & Waghorn 2009). The Victorian government is trialling delivery of IPS in two locations.

A study looking at challenges to implementing evidence-based employment services in Australia raised several issues (Waghorn et al 2007). The major barriers can be classified into three areas: the integration of vocational staff into the mental health team, the risk of isolation from employment staff and client eligibility and access issues (Ibid.).

Issues with integration:

- The time taken to plan and set up integrated services can put pressure on employment services financial sustainability due to performance pressures.
- No specific training programs have been developed for integrated employment specialists or mental health teams.
- Cultural differences can lead to a lack of support from clinical teams who might not think their patients can benefit from work.
- Confidentiality and insurance requirements can restrict cooperation.
- Occupational health and safety issues arising from employment specialists working in mental health units.

Issues with isolation from employment staff:

- There is a risk employment specialists become too involved and focused on clinical needs rather than employment outcomes.
- Employment specialists becoming isolated from other employment staff reducing access to industry information and job opportunities.

Client eligibility and access:

- The current assessment procedures for job seekers accessing employment services can exclude clients based on factors such as not being able to benefit from 8 hours work to not being in receipt of benefit payments. This contradicts the evidence-based criterion of zero exclusion.
- Clinical staff filtering referrals and only sending job seekers who they characterise as job ready to employment service providers

Minor issues identified by the study were as follows:

- Limiting active caseloads to a maximum of 25 job seekers per employment specialist.
- Perceptions of inequity can grow from the different size of caseloads for integrated employment specialists and other employment specialists.
- Difficulties maintaining financial sustainability during initial phase due to small initial caseloads and a reliance on case-based funding outcome payments.
- Preserving a focus of vocational staff on employment services.
- Monitoring of work performance and attitudes to improve job retention.
- Avoiding delays in starting job search caused by capacity assessments and income support eligibility
- Ensuring follow-up support for job seekers isn't curtailed due to DES and JSA funding arrangements.
- Avoiding office-bound services.
- Proactively reaching out to clients to improve employment outcomes.
- Calculating the implications of returning to work on social security payments.
- Proving assistance with education.

The use of a regional trainer and Centre for Excellence could help overcome issues of implementation and ensure high fidelity. A State Trainer programme has produced successful results in 13 States in the US (Centre for Mental Health 2012). Using an online database would allow for the dissemination of knowledge and improve implementation issues. Regional trainers can help skill up employment services, bring about organisational change and conduct fidelity checks to ensure the program veracity. These experts can also assist in the development of action plans to overcome barriers. The provision of a centre for excellence would

also allow for support to be provided in setting up and improving services. There is already a significant group of IPS experts in Australia which would aid in the development of such a service.

A study from the USA suggested that due to reductions in welfare payments, increased taxes, and decreased use of public health services, the implementation of evidence based IPS supported employment for people with mental illness could be achieved at little or no cost to government (Drake et al 2010). Two reviews put the costs of IPS services per job seeker in the first year of service at US\$4000 in 2006 dollars (Latimer et al 2004; Salkever 2010). A Canadian study suggested it could be funded across Quebec for half the cost of current ineffective services (Latimer et al 2011). A study across six European sites found that not only were results in IPS employment services better than treatment as usual but were also more cost effective (Knapp et al 2013). Given the large current investment in employment services in Australia it is likely IPS could be implemented without additional expenditure.

A New Zealand study found that integration was difficult but focussing on other key fidelity measures allowed the service to achieve good employment outcomes

(Browne et al 2009). The study found that the design of funding contracts can support the implementation of evidence-based practices.

Recommendations

- Work toward a new contract framework for specialist employment services working with people with mental illness which better supports the implementation of the IPS model. Such a contract could set absolute standards for outcomes based on historical data while using the fidelity measures as a quality assurance performance evaluation framework.
- Through the COAG processes move to insert measurable performance requirements around integration of federally contracted employment service providers with State contracted mental health services.
- Further development of Social Firms and Clubhouses in order to offer a holistic approach to employment services for people with mental illness.
- Establish a national centre for excellence in evidence-based employment services to disseminate information on best practice, train employment specialists & work on improvement plans and undertake auditing of fidelity to the IPS model.

Section 5: A new approach

This section proposes a new way to approach education and employment interventions for young Australians with mental ill health. It takes advantage of work that has already been done evaluating IPS supported employment in young people with severe mental illness. It also uses an existing service structure for delivery.

As detailed in this report, the traditional approaches to employment have failed for people with mental illness. As a consequence as a group they are more unemployed and greater recipients of DSP than any other disability group. A new approach is needed.

Government policy through the National Mental Health plans has been for mental health services to have a recovery focus. At the same time, the importance of early intervention has been recognised through the establishment in 2006 of headspace. There are currently more than 60 headspace centres around Australia providing primary mental health care for young people aged 12-25. In addition headspace will soon be launching 9 specialist early psychosis services. Marrying the early intervention focus of headspace to the evidence based effectiveness of IPS employment services would lead to significant gain for young people with mental illness in terms of educational and employment outcomes.

headspace

headspace is a nationally funded mental health organisation providing care to young people with mild to moderate conditions (headspace 2011). Since its inception in 2006, headspace has helped more than 100,000 young people (headspace 2012/13).

The federal Department of Health provides funding to the headspace National Office. Consortia bid to establish headspace centres in local areas. The successful centres are then provided with funding from headspace national office. Clinical services are provided primarily through medicare funding. Employment is one of the four pillars of headspace. In most situations, this is achieved through inclusion of an employment agency in the bidding consortia, or through referral to local employment agencies.

Two problems are apparent in the current orientation of headspace vocational services. One is that many people going to headspace who could benefit from government funded vocational services are not eligible because they are not yet on a benefit and their illness has not yet developed to the stage where they would be incapacitated enough to qualify to access DES. This means a person has to wait until they are eligible for employment benefits before they can gain the assistance of employment services even if they face the significant barriers to the labour market presented by mental health conditions.

The second problem is that the provision of employment services is not necessarily co-located with the rest of the headspace services. It may be in the same building, but it could be in another building completely. The benefits of co-location are thus not achieved.

The advent of the early psychosis clinics in some headspace sites offers an intriguing glimpse of what might be possible. The new early psychosis services have to provide 16 elements in their services for young people. One of these is that they need to employ an IPS worker to provide educational and employment recovery services to young people (Stavely et al., 2013). Exporting this model to the wider headspace centres would be a great leap forward in both the provision of true recovery oriented services, as well as holistic early intervention.

the traditional approaches to employment
have failed for people with mental illness ...
A new approach is needed

This could be done through the reallocation of some money from the employment services to headspace for the employment of dedicated IPS workers in headspace centres. Alternatively, existing employment agencies could continue their partnership with local headspaces by agreeing to provide high-fidelity IPS services. This would require a change in practice for many agencies, but would lead to better outcomes in terms of employment and education for young people with mental illness.

Recommendations

- Introduce federally funded IPS employment and education services as part of the headspace model that do not require assessment or social security benefit eligibility to improve both education attainment in younger people and transitioning to the workforce for the slightly older cohort.
- Improve the implementation of evidence-based employment services by establishing an accreditation system for providers based on high fidelity to evidence-based practices.

Section 6: Recommendations

This report has reviewed the landscape facing young people with mental illness who wish to pursue educational and employment goals. Our strong recommendation is that a refocusing of strategy to the delivery of IPS employment and educational services should be provided through the headspace platform. This is likely to be the best method of achieving the government's policy aims by providing a viable and evidence based method for people to avoid commencement on the DSP. For those on a DSP, IPS is a bridge back to education, training and employment. To that end the following key recommendations are made. Other recommendations arising from our review of this area then follow.

- Fund high fidelity IPS employment and education services to be provided to young people presenting to headspace centres around Australia. These services would be fully embedded and come under the governance of headspace. This could be funded from a range of current funding sources.
- Use the headspace national dataset to capture the data about an integrated model and use this to evaluate and refine the provision of these services.
- Using lessons from the scaling up and implementation of IPS at headspace centres, expand IPS services into mainstream community mental health services for all mental health consumers who wish to work or return to study.
- Develop anti-stigma campaigns targeting employers, families, young people and primary care providers to break down attitudes that imply that young people with mental illness cannot or should not work.
- Educate mental health clinicians about the importance of employment and education as a part of, not the product of, recovery. Such a program to be led by the National Centre of Excellence in Youth Mental Health.
- Through the provision of comprehensive early intervention services that address both symptomatic and functional needs, provide a viable pathway to return to employment and education.

Recommendation: Treatment rates.

- Create a new Medicare benefit class for people under the age of 25 receiving treatment that either:
 - requires bulk billing; or
 - provides psychologists and psychiatrists with a slightly higher payment in exchange for getting rid of co-payments.

Recommendation: Education

- Develop a nationally consistent approach to funding and supporting programs aimed at engagement (and re-engagement) and wellbeing to address inadequate funding and reduce differences between jurisdictions in policy and practice.
- Improve staff to student ratios in important programs such as Student Support Services Officers through increased funding attached to disadvantaged students and schools.
- Improve funding structures for alternative education settings that deal with students who are receiving clinical treatment.

- Develop supported education policies in mainstream settings for students before they are referred to mental health services with funding structures that allow for growth.
- Continue to work with schools, students and parents to promote mental health literacy and enhance resilience and support teachers to recognise issues and refer students with mental illness to someone better placed to treat the condition.

Recommendation: Employment Services Star Ratings

In order to remove perversities created by current Star Ratings system, the Government should:

- Introduce absolute benchmarks for different disability groups based on historical data

Recommendation: Employment Services Funding Structure

Remove perverse incentives to overinflate caseloads and park or set aside the most disadvantaged job seekers by:

- Abolishing service fees and moving funding to outcome payments.
- Including quality of service and regular contact requirements in performance evaluation.
- Allow employment service providers credits or a portion of their funding based on their expected levels of job placements, 13 week, 26 week and 52 week outcomes. Any difference in expected outcomes and the actual outcomes achieved could then be recouped at the end of the financial year.

Option two:

- Reduce levels of service fees and introduce requirement that funding must be spent on the job seeker and not within the employment service.

In order to improve incentives to providing quality services:

- Attach an outcome payment to the 52-week outcome indicator. This would promote long-term employment options and incentivise employment service providers to seek sustainable work options.
- Introduce 65-week outcome payment.
- Investigate possible contract requirements to limit active caseload size to 25 job seekers per employment specialist.

Recommendation: Full outcomes vs Pathway outcomes

- Allow employment service providers to claim both a pathway outcome and full-outcome for young job seekers suffering mental illness who have low levels of education. This could be done on a pro-rata basis. If the job seeker achieves an employment outcome after a pathway outcome then the difference in the fees could be paid to DES providers.

Recommendation: Ongoing support

Two options for removing the disincentive to offer ongoing support to jobseekers most in need:

- Eliminate the perverse incentive to remove job seekers at risk of losing their job and in need of ongoing support by using the number of successful ongoing support participants as a bonus factor in performance evaluation instead of the proportion of successful ongoing support outcomes.
- Remove ongoing support as a measure that affects star ratings and simply reward ongoing support outcomes with current funding arrangements.

Recommendation: Assessment processes and classification

- Introduce a scale such as the PSP for assessment of mental health conditions to better capture the needs of this cohort of job seekers.
- Streamline employment services assessment procedures for people with mental illness already on the DSP. This category of people should be encouraged to access employment services through the DES system and should not be allocated a prescribed hourly benchmark or face lengthy delays caused by assessment procedures. Any amount of work should be seen as a positive outcome in their journey to recovery.

Recommendation: Disability Support Pension

- Require people with mental illness under the age of 25 to return to Centrelink once every three months to determine whether Disability Employment Services could help. This should not affect DSP eligibility. Instead it involves checking to see how the episodic impairment is progressing and if vocational rehabilitation should be considered as an option.
- Once a person has been deemed eligible for the DSP they should be able to return quickly to payments if they have tried to return to work and their condition has deteriorated. This means that a person who tries to work when on the DSP succeeds in finding a job and has their payment reduced to zero can rely on a safety net if their disability or illness gets worse.
- Introduce independent benefits counselling. In order to counter perceptions that working while on the DSP will leave the person worse off more information must be provided.

Recommendation: Evidence-based employment services

- Work toward a new contract framework for specialist employment services working with people with mental illness, which better supports the implementation of the IPS model. Such a contract could set absolute standards for outcomes based on historical data while using the fidelity measures as a quality assurance performance evaluation framework.
- Through the COAG processes move to insert measurable performance requirements around integration of federally contracted employment service providers with State contracted mental health services.
- Further development of Social Firms and Clubhouses in order to offer a holistic approach to employment services for people with mental illness.
- Establish a national centre for excellence in evidence-based employment services to disseminate information on best practice, train employment specialists & work on improvement plans and undertake auditing of fidelity to the IPS model.

Recommendation: headspace

- Introduce federally funded IPS employment services as part of the headspace model that do not require assessment or social security benefit eligibility. This would help improve both educational attainment in younger people and their transition to the workforce.
- Improve the implementation of evidence-based employment services by establishing an accreditation system for providers based on high fidelity to evidence-based practices.

Section 7: Conclusion

This report has examined a number of the barriers to the participation in employment and education of young Australians with mental illness. Several recommendations have been identified which if implemented will lead to greater participation of this group in the workforce. This is an inherent, social and economic good. The Australian Government must implement evidence-based employment services for people with mental illness as a matter of both social and economic urgency. There has been significant recent discussion about the DSP and reforms associated with it. People with mental illness are the biggest group on the DSP and yet survey after survey finds that as a group they want to work. They do not want to be dependent on benefits. What has been missing in the discussion is the method by which a bridge is created from the DSP to sustainable employment. Even less discussed is how to assist people to not need to get onto the DSP in the first place through supporting them to complete education and transition successfully into the workforce. Individual Placement and Support fits this brief when applied early in the course of illness. Its high employment success rate and easy adaptation to educational support make it deserving of policy support and practice implementation.

Too often young people with a mental illness who wish to further their education or seek employment are told that they are dreaming if they think it is possible to do those things with a mental illness. Despite prevailing stereotypes, stigma and well-meaning but misdirected carers and clinicians, young people with mental illness continue to hold tight to their dreams of a future that involves a meaningful role and social and economic participation. They hold these dreams despite the barriers that stand in their way. Increasingly, evidence shows that there are ways for young people with mental illness to reconnect with their vocational dreams. It is incumbent on all stakeholders to identify practices and policies that currently prevent this and work to remedy those policies and practices that can be remedied. Where remedy is not possible it is imperative to develop new policies and practices. This report makes a contribution to this process.

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