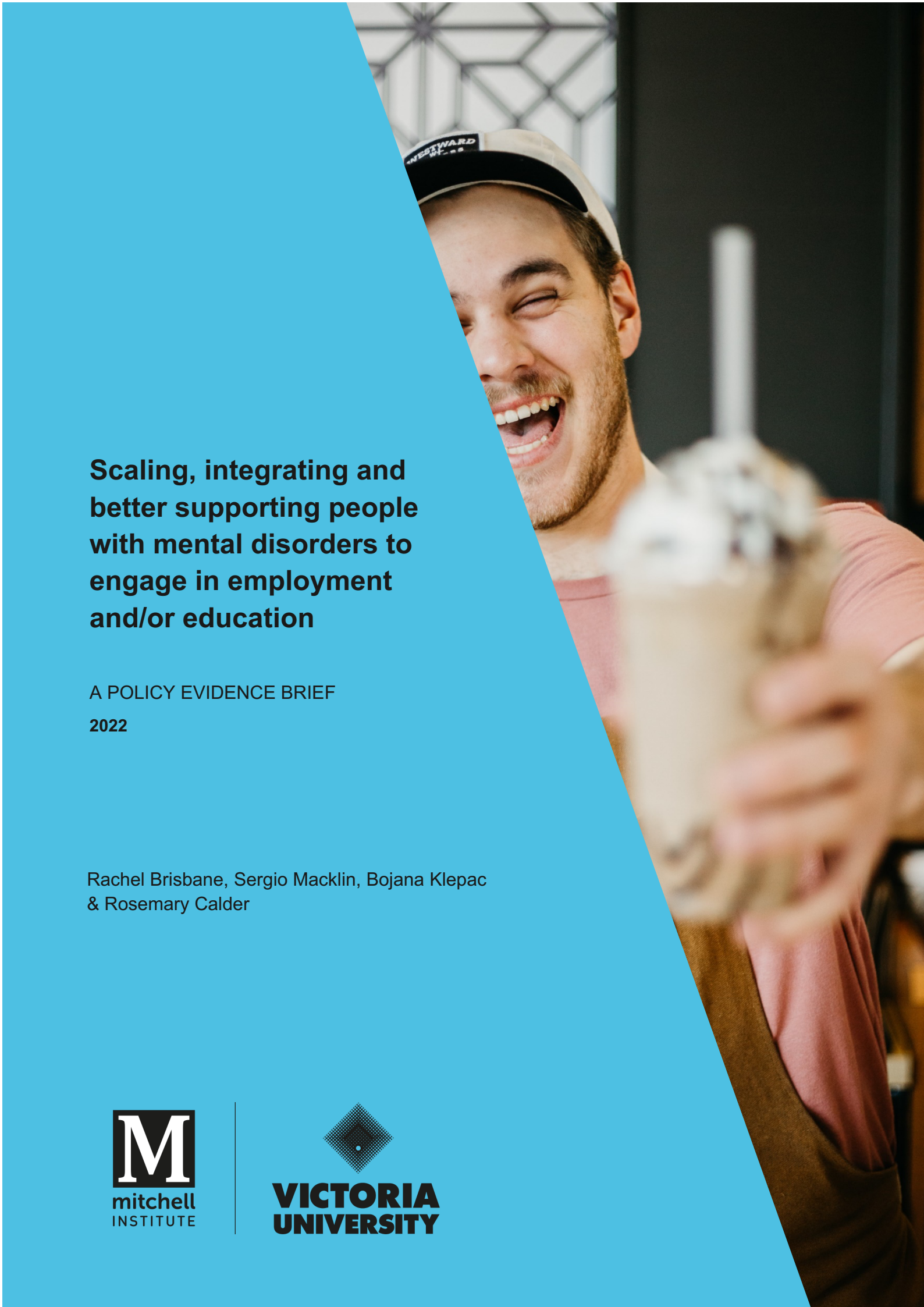

Scaling, integrating and better supporting people with mental disorders to engage in employment and/or education

A POLICY EVIDENCE BRIEF

2022

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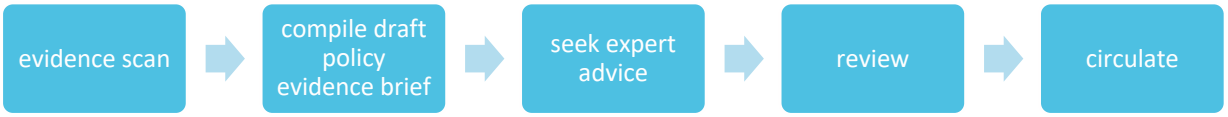
The Mitchell Institute's policy evidence briefs are short monographs highlighting the key evidence for emerging or pressing policy issues. We work with our partners in the Australian Health Policy Collaboration to seek expert advice on topics, content and context.



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Abbreviations

ABS	Australian Bureau of Statistics
ACFE	Adult, Community and Further Education
AHPC	Australian Health Policy Collaboration
CDP	Community Development Program
DES	Disability Employment Services
DSP	Disability Support Pension
ECEC	Early Childhood Education and Care

GP	General Practitioner
IPS	Individual Placement and Support
IPSEd	Individual Placement and Support Education
NDIS	National Disability Insurance Scheme
OECD	Organisation for Economic Co-operation and Development
PHIDU	Public Health Information Development Unit
SEd	Supported education
VET	Vocational Education and Training

Executive Summary

Australians with severe and persistent mental disorders experience some of the highest rates of unemployment. Yet people who live with these mental disorders want to work. The evidence demonstrates that engaging in meaningful work improves not only their health but their access to the financial, social, and other resources necessary to improve their mental health and quality of life whilst reducing dependency on the health and welfare systems.

There are several reasons that finding and maintaining employment is difficult for this group.

As the majority of severe mental disorders emerge before 25 years of age, schooling and vocational education is often disrupted if not completely derailed. Low educational attainment is linked with negative employment, health and wellbeing outcomes, that compound for young people over their lifetime.

The evidence indicates that existing welfare assessment processes misclassify many people with mental disorders, and this results in them receiving inadequate levels of support. Furthermore, the difficulties of coordinating services across health, education and welfare systems raised in multiple reports largely remains meaning that many people living with mental disorders do not get the support they need to break the pattern by re-engaging with education and securing meaningful employment.

Many people with mental disorders who meet eligibility criteria to access disability employment services (DES) report that recovery-oriented practices were not consistently implemented within these services. Indeed, recent data shows that only 10% of with a psychiatric disability using DES will maintain employment for six months. Existing employment services for people with mental disorders cost Australia more than half a billion dollars each year and are not effectively supporting people with mental illness into work.

People living with a wide range of mental health conditions also report the negative impact of widely held misperceptions and stigma about mental disorders and employment. For people living with mental disorders, this often results in a lack of encouragement from health professionals to participate in employment. In addition, employers often lack the knowledge of simple accommodations to better support employees living with mental disorders. This creates further barriers to successfully gaining and maintaining meaningful employment.

Improving outcomes for this group requires a multifaceted approach. This includes evidence-based interventions to support people living with mental disorders to secure and maintain meaningful employment. Moreover, addressing low employment outcomes requires reforms that better support young people with mental disorders to stay in school and where a young person's education has been derailed completely, providing supports to re-engage with education that aligns with their vocational aspirations.

The evidence strongly demonstrates that the most effective intervention to improve employment outcomes for people with mental disorders is the Individual Placement and Support (IPS) program. Peer-reviewed studies from Australia and around the world have consistently shown that the IPS model achieves better employment outcomes than those achieved by the current Disability Employment Services (DES) model. Whilst IPS is frequently utilised to help people with mental disorders gain and maintain employment, it has been shown to be effective with other cohorts who need more support (such as veterans). IPS has been successfully trialed in Australia and has been expanded as a service offered within 50

headspace youth mental health centres. In addition, it is available through some DES providers.

The vocational specialists employed within IPS programs have an important role. When located within mental health services, these specialists reinforce the valuable part employment plays in recovery, and this can help alter misperceptions held by health workers. Vocational specialists can provide knowledge and support to employers about reasonable accommodations for employees with mental disorders and, more generally, contribute to breaking down stigma in society.

There are fewer peer-reviewed interventions targeting school-aged young people to remain in school, or where they have disengaged with the school system, to engage with vocational education. Recently, a modification of the IPS program was piloted in Australia to investigate whether the principles of IPS could be applied to assist youth with mental disorders to re-engage with education (IPSEd). This program showed promising results. The Victorian Doctors in Schools pilot program has also demonstrated promising outcomes within the first 12 months of implementation. This program locates doctors within the secondary school environment to help students access healthcare. The evidence suggests that co-locating services improves integration between services, reduces barriers and improves access.

Building upon the many successful trials of IPS, the next step is to establish a national high fidelity IPS rollout that expands the program, making it available more widely to include adults and to fully align with the zero-exclusion principle of IPS. Integrating services within schools that support good mental wellbeing and encourage young people with emerging and diagnosed mental disorders to stay in school is a complementary and necessary policy.

Introduction

Worldwide, the prevalence, impact and burden of mental disorders is increasingly recognised [1] and Australia is no different [2]. In any year in Australia, 1 in 5 adults (20%) and 1 in 7 children (13.9%) will experience a mental disorder [3] of some kind. The prevalence of these disorders increases to nearly 1 in 3 (27%) young adults (18-24 years of age) [4]. Almost half the population (45%) will experience a mental disorder at some time in their life [3]. While these disorders range in nature and severity [2], for many they have significant effects, including negatively impacting people's ability to secure stable and meaningful employment [5-13].

The proportion of people with a mental disorder who are unemployed is 17 percentage points higher than the rest of the population and the proportion not in the labour force (unemployed and not looking for work) is 15 percentage points higher [14]. Unemployment rates for people with moderate and severe mental disorders are up to five times higher than in the general population [6]. Moreover, this is despite evidence showing that the majority of people with mental disorders want to work [5, 8, 15-17] and that employment substantially improves their mental health [5, 15, 17-20] and quality of life [18, 20].

People with mental disorders face significant additional barriers to finding and securing meaningful work [16]. These range from lower levels of educational attainment [1, 9-12, 16, 20-22] to higher levels of discrimination and stigma in the workplace [1, 6, 17, 23-26]. Additionally, people with mental disorders are often required to navigate multiple, complex and poorly connected government systems, and often are still not able to access the support they need [6, 27, 28].

To reduce gaps in employment outcomes for specific groups in the population is complex, involving different levels of government and multiple service systems [27]. There is clear evidence about the reforms that are needed [6, 28, 29] and there have been a number of inquiries that have recommended implementation of an established and evaluated program, Individual Placement and Support (IPS) to improve existing employment support for people living with mental disorders. Despite the evidence and the outcomes of inquiries, existing supports remain disconnected, difficult to navigate, and in some circumstances act as a hindrance to employment [6, 28-30]. Commonwealth employment programs have been shown to have lower success rates for people living with mental disorders than for people living with other disabilities [30, 31] and lower than those achieved with international best practice employment models [5, 15, 19, 32-36]. While some progress has been made, particularly in providing employment supports for young people with mental illness [37], there is significant room for improvement.

Effectively addressing barriers to securing meaningful work and improving government supports for people with mental disorders will not only reduce gaps in employment. Employment has been shown to improve quality of life, has the strong potential to improve health outcomes, and reduces use of the healthcare system, particularly acute, crisis and emergency services [29, 38]. Additionally, reducing gaps in employment would also provide significant benefits to government, including improved productivity, increased tax revenue, and reduced expenditure.

This policy evidence brief addresses the policy priority identified by the Australian Health Policy Collaboration (AHPC) in *Getting Australia's Health on Track 2016* [39] which recommended vocational programs to enable positive employment outcomes for people with moderate and

severe persistent mental disorders. The AHPC urged the scaling up and better integration of these programs to reduce the impact of unemployment on the mental and physical health and wellbeing of Australians with a mental disorder, and to reduce the annual cost of lost productivity in the national economy. As discussed above, there has been little policy response to the recommendations made by expert bodies and inquiries.

This brief is intended to provide further policy information in support of the growing body of opinion that investment in evidence-based employment support for people living with mental disorders is a pressing policy priority that will benefit health outcomes and reduce preventable income insecurity for individuals.

The brief considers the evidence and potential policy solutions to scale, integrate and better support people with mental disorders to engage in meaningful education and/or employment. The report comprises three sections: the first section describes and analyses differences in employment outcomes between the general population and people with mental disorders. This explores existing barriers to employment and issues with current policy settings. The second section outlines the evidence on the most effective approaches to improve employment outcomes for people with mental disorders. The third section sets out recommended policy options, including key considerations in relation to their implementation.

The problem

People with mental disorders have some of the highest rates of unemployment, despite wanting to work

The majority of people with a mental disorder want to work. In particular, people with severe mental disorders [5, 17, 20] overwhelmingly report that they want to work [5, 8, 15-17, 20, 40, 41]. Most importantly, they see work as a crucial part of their recovery [15, 20, 40, 42], yet they frequently report they are unable to access adequate support to gain and maintain employment [16, 18, 22, 41].

Despite this strong desire to work, people with a mental disorder [39] find it more difficult to secure and maintain employment, and those who do find employment are likely to earn less [6]. Diagnosis of a mental disorder, particularly a moderate or severe illness, increases an individual's chance of becoming long-term unemployed [5, 36]. Moreover, employment rates decline as the severity of illness increases [6]. Young people with severe mental disorders are less likely to have completed high school [10, 25].

The 2011-12 National Health Survey reported that around 3% of Australians without a mental disorder were unemployed, compared to 7.5% of people with a moderate disorder, and approximately 16% of people with a severe disorder [43]. That survey did not report on people who were not in the labour market.

The National Health Survey 2014-15 reported that 60.7% of Australians aged 15-64 with a mental or behavioural condition said they were employed, 8.4% reported being unemployed, and 30.7% reported they were not in the labour market [14].

The most recent unemployment rates reported in the 2017-18 Australian Bureau of Statistics (ABS) National Health Survey show that (Figure 1):

- 62.1% of Australians aged 15 to 64 with a mental or behavioural condition were employed, compared to 79.5% without those conditions [44].
- 5.6% of Australians aged 15 to 64 with a mental or behavioural condition were unemployed, compared to 3.5% without those conditions [44].
- 32.2% of Australians aged 15 to 64 with a mental or behavioural condition were not in the labour force, compared to 17.0% without those conditions [44].

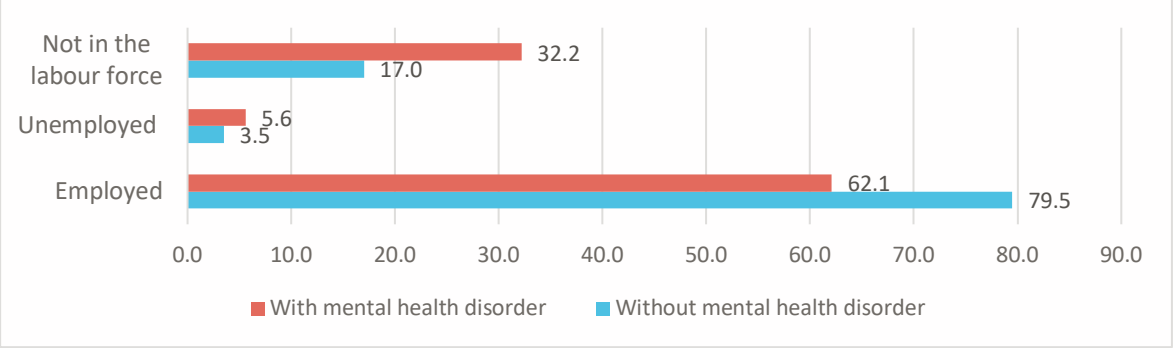

Figure 1 - Proportion of Australians aged 15-64 years, by labour force status and mental health status

Source: ABS, National Health Survey: First Results 2017-18 [44]

While the proportion who reported being unemployed declined between these surveys, the proportion not participating in the labour market appears to have increased between the latter time period. [14, 44] This group is likely to be further away from reaching an employment outcome as they are not engaged in employment seeking activities.

Figure 2 illustrates the influence of mental health condition on participation in employment and the labour force, as reported by the National Health Survey 2017-18. The proportion of people not in the labour force ranged between 40% and 50% for most mental disorders. However, among people with schizophrenia related conditions this increased to 76%, meaning more than three in four people with these conditions were unemployed and not looking for work. As this group overwhelmingly reports that they want to work [5, 8, 22], there is considerable scope to improve this situation.

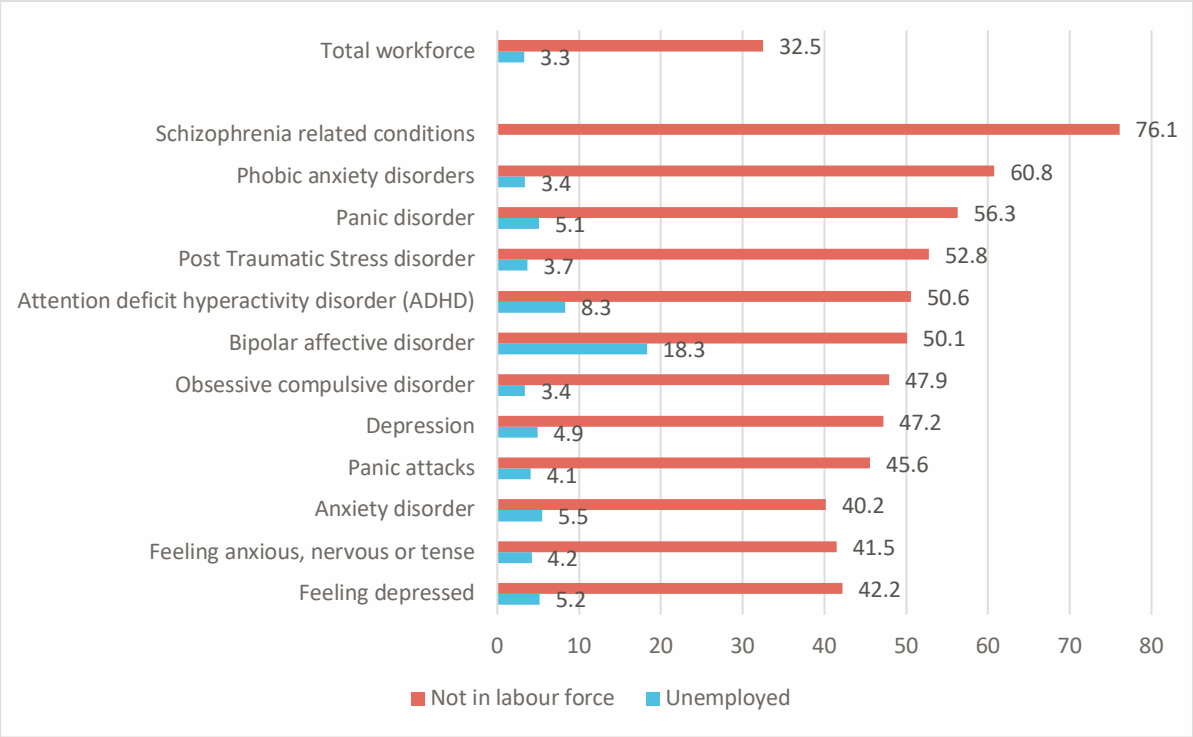

Figure 2 - Proportion of working age population (aged 16-64 years) that are unemployed and not in the labour market, by selected mental illnesses

Source: Reproduced from the Productivity Commission's Mental Health Appendices (page 70) [6], based on the Australian Bureau of Statistics National Health Survey, 2017-18 [44].

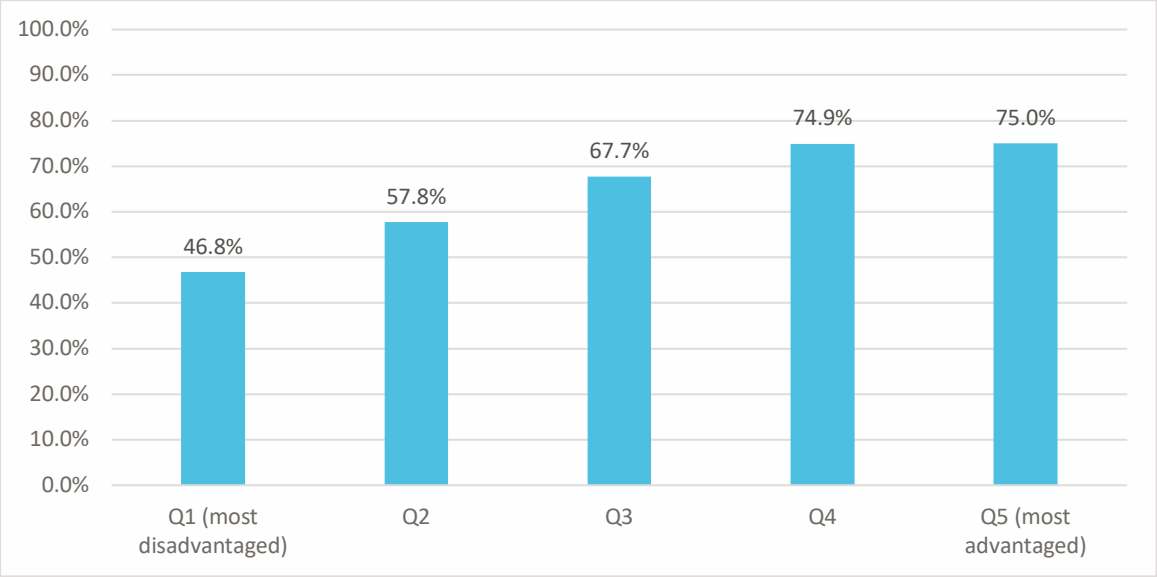

Figure 3 further illustrates the relationship between mental illness and unemployment in the context of socio-economic disadvantage. It shows less than half of people with a mental disorder in the most disadvantaged communities were employed in 2017-18, compared with three quarters of people with a mental disorder in the most advantaged areas. This shows that, in addition to differences based on severity of disorder and type of condition, there is a clear social gradient related to the employment of people with mental disorders.

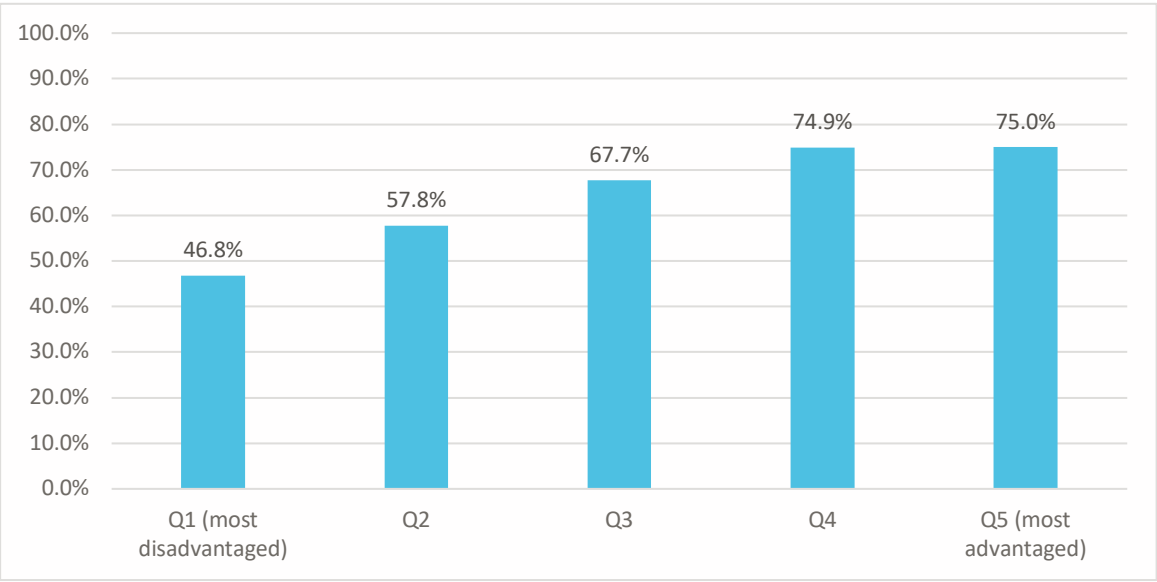

Figure 3 - Employment rates amongst people living with mental health conditions by socio-economic status

Source: created with 2017-2018 data analysed by the Public Health Information Development Unit (PHIDU).

Unemployment increases the risk of poor health, and reduces access to key financial and social resources that support recovery and a quality life

Unemployment and the general population

Unemployment is widely accepted as a negative and stressful experience for the majority of people. Depending on a person's stage of life, the financial distress of surviving on

unemployment benefits [6, 40] can range from uncertainty affecting planning for life goals, having to move away from social and community supports to more affordable housing, being unable to afford clothes suitable for work interviews and the technology to support job hunting, through to poverty and homelessness. Invariably, this financial distress, combined with fewer social opportunities, stigmas around unemployment and dependency on welfare, leads to increased social exclusion [6, 12, 40]. People who are unemployed are more likely to have a chronic disease and multi-morbidities [45]. Lowered self-esteem becomes common [6, 20] and those who were previously well become at risk of developing mental disorders such as depression [6, 20], anxiety [20] and are at increased risk of risk-taking behaviours, such as drug and alcohol use [15] the longer they are unemployed [6]. Longer the periods of unemployment are associated with an increased prevalence and severity of depressive symptoms. In turn, more severe depressive symptoms increase the likelihood of unemployment.[6]. This highlights the bi-directional relationship between mental health and employment. Just as poor mental health can impact a person's ability to gain employment, unemployment can also negatively affect a person's mental health.

Unemployment and People with Mental Disorders

People with a mental disorder, who are already more likely to be unemployed than the general population, are at further risk of poor health, which in turn decreases their chances of gaining meaningful employment and being able to stay employed [6]. People with a mental disorder are at greater risk of developing physical health conditions, and these create further barriers to employment [2, 46-48].

Even common mental disorders, such as depression, are strongly linked to an increase in the onset of a range of physical conditions [47] including coronary heart disease and diabetes [46-48]. In addition, people living with mental disorders are more likely to engage in health risk behaviours including smoking cigarettes [49], drug and alcohol use, lowered levels of physical activity and poor nutrition that further impact their physical health [7]. In the Equally Well National Consensus Statement, four out of five people living with mental disorders reported having one or more co-existing physical health conditions [49] compared to the general population, where only one in four Australians reported having two or more chronic physical health conditions [49]. This combination of both physical and mental health conditions is associated with lower levels of educational attainment and higher rates of unemployment [29]. The 2014-2015 National Health Survey shows that people with both a physical and mental health condition are less likely to be employed than people with only physical conditions [14]. Comorbidities are associated with complex clinical management and increased health costs [29] and reduced capacity with functional activities [49].

Adding to these challenges, people living with mental disorders are more likely to be living in areas of greater socio-economic disadvantage, living alone and with fewer social networks that facilitate job referral [14, 22, 38]. Without employment, there is less money available and other resources to manage and improve their health [6]. This tends to result in an over-reliance on using crisis and emergency health services rather than preventative health services due to the out-of-pocket costs of regular health care [38]. This combination of factors increases the likelihood of long-term unemployment [29], being in distress [29], with multiple health conditions to manage simultaneously [29, 38] and with less support and financial resources [6, 28]. Usually, this negatively impacts an individuals' employment, potential career trajectory and earnings over their lifetime [13, 27].

As the majority (75%) of mental disorders are diagnosed before 25 years of age [4, 7, 42, 50, 51], young adults in particular, begin their working years at a disadvantage. Without adequate support, they are more likely to experience the compounding negative financial, health and social impacts from long-term unemployment over their lifetime [13, 21].

Preventable unemployment increases costs to government

The Commonwealth government provides a range of different payments and services to support people with mental disorders to find work. There are approximately 200,000 people with a mental disorder in receipt of JobSeeker or Youth Allowance. In addition, around 258,000 people receive the Disability Support Pension (DSP) [6] for psychological and psychiatric disorders [2, 52, 53]. The Productivity Commission estimates there may be as many as 785,000 Australians (3% of the total population) with a mental disorder in receipt of one of these three income supports [6] and that, in 2018-2019, income support payments to this population group totaled approximately $10.9 billion across DSP, JobSeeker, youth allowance and various payments to carers [6]. (Table 1).

Table 1 - Productivity Commission Estimates - Income support payments related to mental illness (2018-2019)

Income support payment	Total cost ($ billion)	% mental health related[1]	Cost attributable to mental illness ($ billion)
Disability Support Pension	16.7	35	5.8
Newstart Allowance[2]	9.7	26	2.6
Youth Allowance	0.9	11	0.1
Carer Allowance	2.3	32	0.7
Carer Payment	5.6	27	1.5
Carer Supplement	0.6	N/A	0.2
Total income support payments related to mental illness			**10.9**

Source: Productivity Commission Mental Health Appendices (page 159) [6]

Additionally, each year the Commonwealth spends approximately $520 million on employment support programs to help unemployed people with a mental disorder to find work [6]. This includes $328 million to Disability Employment Service (DES) providers, $139 million to *jobactive* providers, and $53 million on the remote areas Community Development Program [6] (refer to Table 3). In 2018-2019, the Productivity Commission estimated the cost to government of providing health and welfare services relating to mental health as likely to be more than $25 billion [6].

Longer term unemployment experienced by people with mental disorders [5, 6, 25, 36] and subsequent reliance on income supports [15, 20, 25, 36, 40, 52] commonly means this population group is living in highly socioeconomically disadvantaged areas [54]. People in

[1] DSP: Primary medical condition is recorded as psychological or psychiatric, Carer Allowance or Payment: primary medical condition of the care receiver is recorded as psychological or psychiatric, Newstart Allowance and Youth Allowance: the job seeker has a partial capacity to work and reported a mental illness. 6. Productivity Commission, *Mental Health: Productivity Commission Inquiry Report Supporting Material (Appendices B-K)*. 2020, Productivity Commission,: Canberra.
[2] The JobSeeker Payment replaced the Newstart Allowance and some other payments on 20 March 2020. 6. ibid.

lower socioeconomic communities are least likely to use primary health services for preventative mental health care subsidised through Medicare and have the highest use of emergency departments for mental disorders [38]. Improvement in employment outcomes and levels of participation in the labour market for people living with mental disorders could be expected to improve broader health outcomes and reduce preventable demand on some health services. The Productivity Commission estimates healthcare savings on average of $329 million per year are achievable as a consequence of improving the employment outcomes of people with mental disorders [6].

More broadly, people with mental disorders who want to work but are unable to secure work are unable to contribute to productivity and income taxes. Moreover, a lack of employment is often associated with societal problems [7] including family conflict and crime [15].

People with a mental disorder who have secured employment can require additional time off from work or may have lowered productivity whilst at work due to medication effects or reduced functioning. In 2018-2019, the cost to industry of lowered productivity through days away from work, together with reduced, less productive performance due to mental ill-health, was estimated at between $12.2 billion to $39.1 billion [6]. (Table 2).

Table 2 - Productivity Commission Estimates - Estimates of labour market costs due to mental ill-health (2018-2019), $billion

Loss due to:	Lower bound	Upper bound
Lower participation and productivity*	12.2	22.5
Absenteeism	-	9.6
Presenteeism	-	7.0
Total	12.2	39.1

Source: Productivity Commission Mental Health Appendices (page 163) [6]

Informal carers of people living with mental disorders, such as family, partners and friends may reduce the costs of formal care [6], but may have changed their own work arrangements, plans and income in order to do so [25, 29], or have given up work completely and be in receipt of a carer's payment [6].

The fluctuating and episodic nature of some mental health conditions [12, 25] impacts workplaces [21] through absences and lowered productivity [6], for both those with mental disorders as well as working carers [23]. A lack of support from employers in understanding how they can make reasonable adjustments to accommodate employees with mental disorders and carers can further reduce participation and employment outcomes [55, 56].

Unemployment among people with mental disorders has wide-ranging effects on individuals, their families and social networks, and on governments. As shown above, these include expenditure on social security and employment services, as well as increased pressure on

* The lower bound estimate is based on assumptions that the costs captured include not working, working fewer hours and lower productivity for those in employment. Separate estimates for presenteeism and absenteeism are therefore not included. The upper bound estimate assumes the costs captured are attributed to not working or working fewer hours. Any effect of presenteeism and absenteeism is temporary not reflected in wages. Separate estimates for productivity are, therefore, included in the overall total of the upper bound. 6. ibid.

health systems, and reduced productivity. Effectively supporting improved employment outcomes for people with mental disorders will therefore not only provide direct benefits to individuals and their families, but also to governments and the community more broadly.

Findings:

- People living with mental disorders want to work and working improves their health and quality of life.
- Employment improves access to the financial, social, and other resources necessary to improve their mental health and reduces dependency on the health and welfare systems.
- People living with mental disorders experience some of the highest unemployment rates, with unemployment rates increasing with severity of illness, despite the significant investment in Commonwealth employment programs designed to specifically improve this outcome.
- Unemployment contributes to socioeconomic disadvantage and is associated with poorer social participation.

People with mental disorders face additional barriers to employment

The episodic nature of mental illness and age of onset create barriers to employment

The majority (75%) of severe and persistent mental disorders emerge before 25 years of age [4, 7, 42, 50, 51], during a time that is critical for educational attainment [4, 13, 42]. The onset of severe mental disorders during this time means that schooling is often disrupted, or derailed completely, with high percentages not completing secondary education [1, 9-12, 16, 20-22], as illustrated in Figure 4 and Figure 5. Although the long-term consequences can be avoided, too often early school leaving and low levels of educational attainment set up a young person for a lifetime of disadvantage in the labour market [13, 27].

One study found that up to 41% of young people presenting for care for mental disorders were disconnected from education and only 10% were employed [51]. Even brief or transitory episodes have long-term consequences on a young person's study and work trajectory [13]. The consequences of low levels of education then compound over an individual's lifetime [21], resulting in fewer employment opportunities [9, 22] marked by entry level, lower skilled, and lower paid jobs [4, 7, 9, 11, 12, 19, 22].

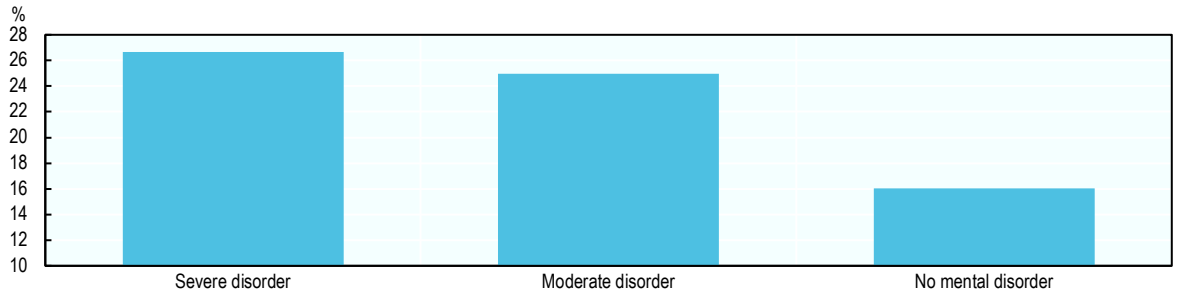

Figure 4 - High-school non-completion rates among young people aged 20 by degree of mental ill health at 18

Source: OECD estimates based on Youth in Focus (Australia).

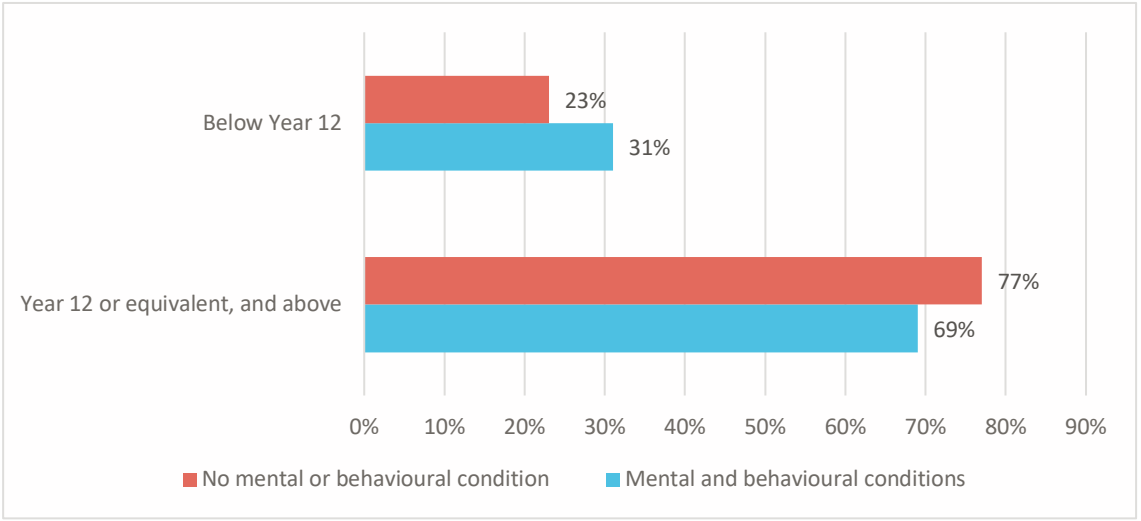

Figure 5 - Proportion of people with a mental or behavioural condition and people without a mental or behavioural condition by level of educational attainment

Source: National Health Survey 2017-18

For those who do secure work, maintaining employment can be more difficult due to the fluctuating or episodic nature of many mental disorders [12, 25] or the side effects of some medications [12] resulting in more frequent work absences [6] that potentially lead employers to negative assumptions about a person's reliability and suitability for promotion [6].

The twenties are a critical age, setting up outcomes across multiple areas of a person's life [57]. Anyone spending additional time out of the labour market during this decade usually experiences long-term setbacks ranging from lower employment progression and household income to delays in forming families and lower health outcomes [57]. Whilst this is consistent for anyone entering their twenties who has not completed high school, or during a broader economic downturn [57], people with a mental disorder are particularly vulnerable to this [1, 9-12, 16, 20-22]. However, in addition to an increased risk of a working life in and out of low paid, entry level jobs, too often the diagnosis of a severe mental disorder becomes a precursor to a pattern whereby unemployment as a young person [8, 12, 25] is followed by a transition to a disability pension [4, 19, 25].

Stigma, discrimination, and a lack of understanding are often barriers to employment

Whilst a lack of education is a significant barrier to employment [22], stigma in workplaces and generally in society [1, 17, 25] is a further barrier to employment for people with a mental disorder.

People with a mental disorder often perceive employers will discriminate against candidates if they know the person has a mental disorder and overlook them in the belief that the person would be an unreliable employee, have lower productivity or even be a liability [6]. Only around one-third of people disclose a mental disorder to their employer [6]. Fear, embarrassment, concerns about discrimination, and heightened scrutiny at work are common reasons for not disclosing [23, 24]. Research suggests that stigma and discrimination is also linked to higher stress, reduced longevity of employment, and disengaging or avoiding work altogether [6, 23].

A national survey conducted from October 2019 to April 2020 provides compelling insights into the stigma and discrimination experienced by people living with complex mental disorders [26]. As shown in Figure 6, 78% reported some level of stigma or discrimination related to employment in the previous 12 months, nearly one in three (31%) of respondents reported frequent or very frequent stigma and discrimination related to work, while a further 28% reported occasional experiences [26]. Other results include:

- Just under 71% (70.69%) of respondents reported they expected to be treated unfairly at their workplace because of stigma about mental disorders [26].
- Respondents reported specific experiences, including being unfairly denied employment (66.79%), promotion (57.18%), and the right to take leave (38.07%), and being asked to leave their job (43.07%) [26].
- A little more than 80% (81.12%) of respondents reported stopping themselves applying for employment opportunities and just over 70% (70.25%) reported stopping themselves applying for promotion activities as a result of stigma and discrimination [26].

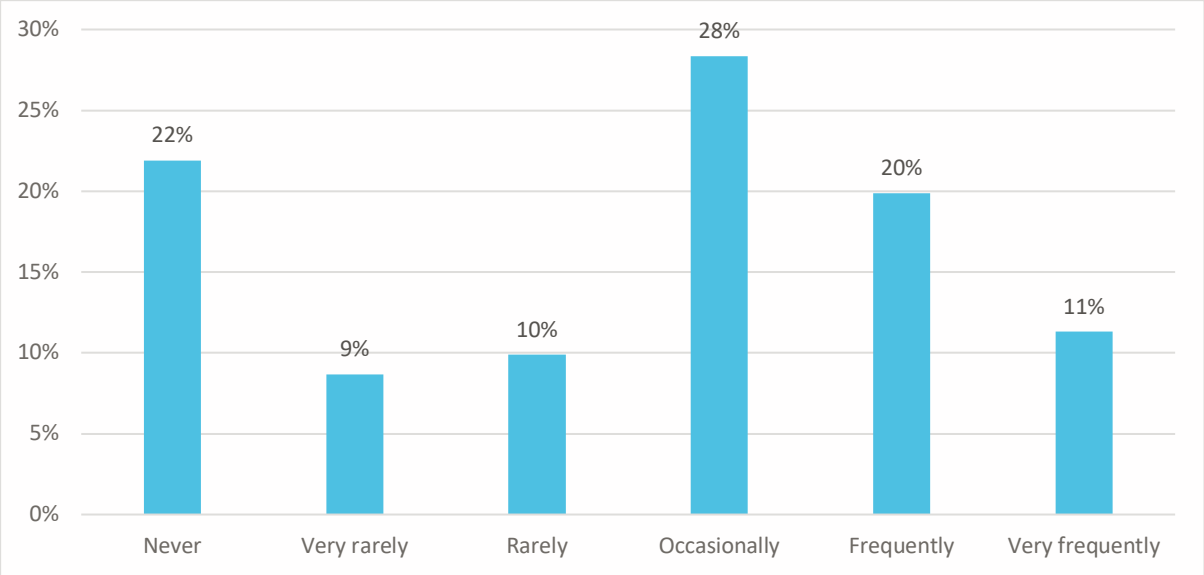

Figure 6 - Proportion of respondents reporting stigma and discrimination in employment.

Source: Beyond Blue, National Stigma Report Card [26]

Employers often do not have knowledge about how to support employees with a mental disorders [55] and what accommodations could be reasonably expected from them [55, 56], consequently reducing the support that employees need [56].

In addition, there are perceptions that can create barriers preventing individuals from engaging in employment applications and interviews. Health professionals, who are likely to see people at times when they are the most unwell, may consider that work will add further stress and burden to a person with a mental disorder [6] and will be detrimental to improvement [20]. This can discourage people with mental disorders from seeking employment [6, 20, 22]. Families, friends and carers may also hold similar views [6]. Low expectations from health professionals and people in close social circles may reinforce to a person with a mental disorder that they cannot work or participate in community life [1, 16], and may contribute to individual identification with a 'sick role' [10]. That can then become reinforced further by continued unemployment [16].

Inadequately coordinated and difficult to navigate services can also create a barrier to employment for people with mental disorders

The consequences of mental health conditions can be complex in nature and the knowledge and resources appropriate to support people may be located across multiple sectors and services [27]. To illustrate, vocational services are rarely perceived by mental health staff as essential treatments in mental health care planning [8, 17, 18, 23, 36, 42]. Mental health services [12, 37], mental health nurses and general practitioners (GPs) who attempt to connect services all report having difficulties navigating employment support systems for individuals [12, 23, 37]. Figure 7 illustrates the various services and systems that have a role in mental illness. It is often up to the individual or their carer to co-ordinate between the fragmented health, social security, education and employment systems and then interface with a range of government and non-government agencies to connect up the services they need [6, 23, 27, 28] – that is, if, when and where services are available [58].

Figure 7 - Responsibilities for mental health care in Australia by sector

Source: Reproduced with permission from Rosenburg and Hickie 2013 [27]

It is estimated that only 35% of the Australians with a mental disorder receive the services they need [27]. There are well documented gaps in mental health care [6, 27], including for:

- people living in regional and rural areas [6, 59],
- people living in areas of greater socio-economic disadvantage [59]
- people transitioning between mental health services based on age [58],
- people who need intensive community support that is not inpatient care [6] or whom have complex needs [58], and
- people who need more support to re-engage with work or education [6, 23, 25].

Lastly, it is well documented that welfare eligibility may disincentivise participation in employment [6, 23]. Recipients of unemployment benefits must continue to meet their mutual obligations which may not be possible for those experiencing episodic mental disorders [6, 23]. The stress associated with this process and fear of payments being cut off are often described as setbacks to recovery [6] with an English study finding similar processes were associated with increased anti-depressant prescribing and a slight increase in suicide rates [60]. Similarly, many people worry that if they do find employment and are unable to maintain it due to the episodic nature of mental disorders, that they will be left in a more precarious financial situation [23]. The Disability Support Pension is often considered to provide more security for those who can meet the permanent disability criteria [23].

The lack of integration between service and support systems means many people with mental disorders do not get the level of co-ordinated care they need to fully support their health and recovery [58]. Although the majority of people with a mental disorder want to work [5, 8, 15-17, 20, 40, 41], the lack of effective co-ordination within the mental health care system [58], and integration with the social security and employment support systems, acts as a barrier to discourage and disincentivise individuals from seeking employment [6, 30].

Findings:

- The majority of severe mental disorders emerge before 25 years of age, often disrupting or derailing school and vocational education.
- Low educational attainment is linked with negative employment and health and wellbeing outcomes for young people that compound over a lifetime.
- Perceptions held by some health professionals along with stigma and discrimination in workplaces act as barriers to potential employment for individuals.
- The difficulty of co-ordinating services and support across health, education and welfare systems means many people living with mental disorders do not get the support they need to break the pattern and re-engage with education and employment.

Current employment supports and outcomes for people with mental disorders

The three main national employment support programs are *jobactive* (general employment support), *Disability Employment Services* (DES – a program for people with a disability), and the *Community Development Program* (CDP – a program for people in remote areas) [6]. People on *JobSeeker* and *Youth Allowance* income support must participate in one of these programs and some people in receipt of the Disability Support Pension must participate in DES [6].

The cost to provide these three employment services programs to the approximately 450,000 people with a mental disorder is just over $520 million per annum [6]. This is in addition to income support payments costing approximately $10 billion annually [6] (refer to Table 1 and Table 3). However, employment outcomes for people with mental disorders remain low including through DES providers [30]. This is also potentially an underestimate of the true figure, given that the Productivity Commission estimates the number of people on welfare support with a mental disorder is potentially closer to 785,000 [6].

Table 3 – Productivity Commission – How many people with mental illness receive income or employment support? [*]

Payment or program	Number of people	Estimated cost of payments or program for people with mental illness (2018-19)[**]
Income support payment		
Newstart Allowance[***]	181 700 deemed to have a mental illness	$2 578 million
Youth Allowance (job seeker)	9 200 deemed to have a mental illness	$98 million
Disability Support Pension	258 600 with a primary psychological or psychiatric disability	$5 774 million
Employment support programs		
Jobactive	85 100 deemed to have a mental illness	$139 million[****]
Disability Employment services[*****]	95 700 with a primary psychiatric disability	$328 million
Community Development Program[******]	3 800 deemed to have a mental illness	$53 million

[*] The number of payment recipients in 2019-20 is likely to be significantly higher as the COVID-19 pandemic continues to affect unemployment rates and the broader economy. 6. ibid.
[**] Estimate is the product of the total program cost (as provided in the Department of Social services and Department of Jobs and Small Businesses Portfolio Budget Statements for 2019-20) and the proportion of recipients/participants with mental illness, psychiatric disability or psychological or psychiatric disability. 6. ibid.
[***] The JobSeeker Payment replaced the Newstart Allowance and some other payments in March 2020. 6. ibid.
[****] The estimate was supplied by the Department of Education, Skills and Employment and is equivalent to the value of payments supplied by the value of payments supplied to jobactive providers supporting job seekers deemed to have a mental illness. 6. ibid.
[*****] May include other non-DES disability employment support (approximately $35 million in 2018-19). 6. ibid.
[******] Cost estimate uses 2017-18 data. 6. ibid.

Source: Productivity Commission Inquiry Report Volume 1 [29]

There is no publicly available information on the outcomes of people with a mental disorder receiving support through *jobactive*. However, reporting on job seekers with a disability does provide some indication. As shown in Figure 8, in 2019 37.5% of job seekers with a disability achieved a positive outcome (employed or in education), and 28.7% were employed either part or full-time. This compares to 56% of all job seekers that achieved a positive outcome and 46% that achieved an employment outcome. Job seekers with a disability had the lowest rate of postive outcomes of all population groups. A similar proportion of both those employed and job seekers had an education level below Year 10. Additionally, these data show that the labour market outcomes achieved for job seekers with a disability have declined since 2016 [31].

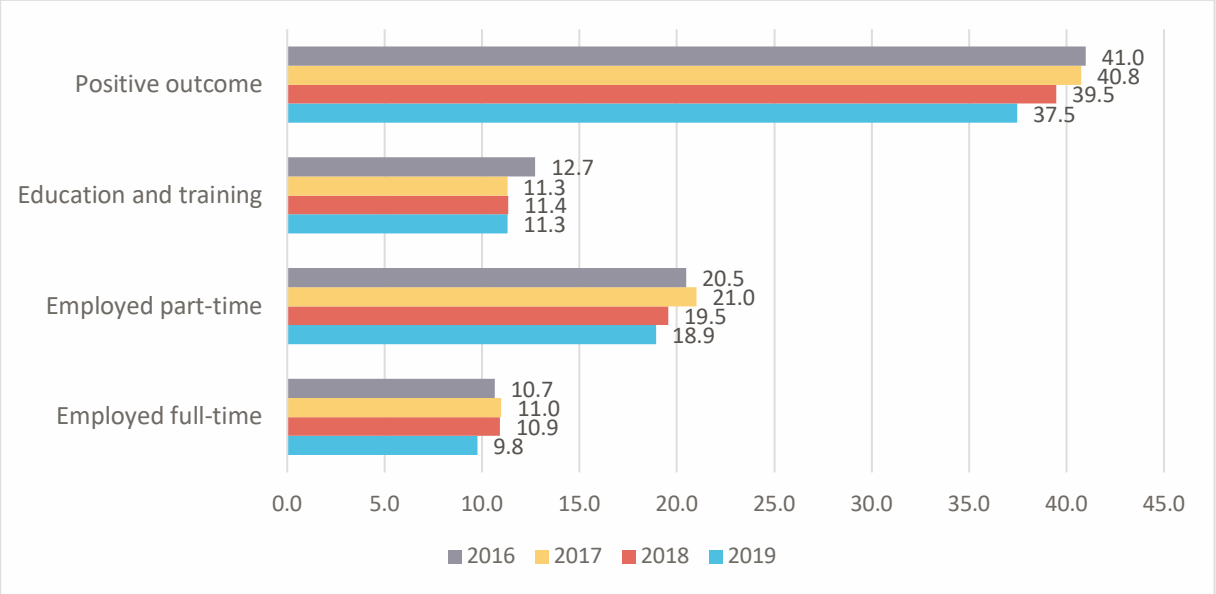

Figure 8 - Proportion of Job Active stream A-C participants with a disability, by labour market outcome (2016-2019)

Source: Australian Government Labour Market Information Portal [31]

Employment outcomes for people with psychiatric disabilities who use the DES are reported publicly. Figure 9 shows the job placement rate and 26-week outcome rate for people with a psychiatric disability. The December 2017 outcomes report shows that 31% of DES users with a psychiatric disability were placed in a job. Of those who found work, 32% remained employed after six months. Therefore, only around 10% of people with a psychiatric disability who used DES both gained and sustained employment for six months. The job placement and 26-week outcome rates for people with a psychiatric disability have remained stable in recent years.

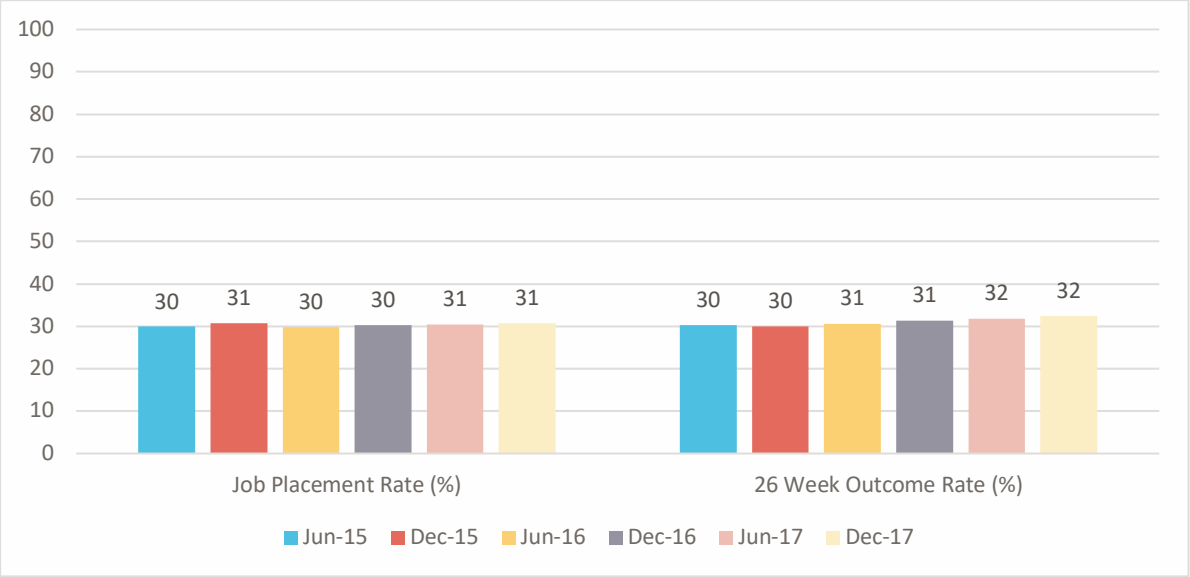

Figure 9 - Proportion of DES participants with a psychiatric disability, by labour market outcome (2015-2017)

Source: Australian Govt, Labour Market Information Portal: DES Outcome Rates by Disability Type [31]

Orygen Youth Research has shown that deficient assessment processes contribute to inadequate levels of support for people with serious mental health conditions. [25]. The second Australian survey of psychosis estimates that around one-third of people with psychotic disorders [22] and one-third of young people with severe mental disorders are misclassified in welfare assessment processes and funneled into general unemployment benefits [22, 25]. As a result, they often find themselves ineligible for the higher levels of vocational support provided through DES [25]. Without appropriate support, the prospect of remaining unemployed remains high [6].

DES relies on the National Disability Insurance Scheme (NDIS) providing additional pre-vocational and other supports to assist an individual with work [30]. However, this assumes that appropriate support services are accessible and are available at the right time [30, 58]. As an example, people with severe mental disorders often require support to develop skills that are wider than job seeking skills, such as parenting and home management, that underpin success in work [21]. There is currently limited or no responsibility for co-ordination [6, 58] of these types of services or other services, such as housing [30] and other disability services [58]. Often these issues are not addressed by services and left up to the individual [58], further reducing their ability to succeed at work.

Despite improvements to the DES system, the current model for employment support continues to be problematic for people with mental disorders [6, 25, 28-30, 32] who report that recovery-oriented practices are not consistently adopted [61].

Trials consistently demonstrate that the specialist mental health Individual Placement and Support (IPS) employment support program achieves better long-term employment outcomes for people with a severe mental disorder and first episode psychosis [8, 10, 11, 19, 33]. A range of overseas trials show competitive employment success rates of around 60% compared to other vocational programs achieving around 25% [33]. The IPS program has been trialed through the Australian Government's Youth Employment Strategy to improve the educational and employment outcomes of young people aged up to 25 with mental disorders. Implementation of the program through a range of youth mental health services has integrated

employment and vocational services with clinical mental health and non-vocational support and is focused on supporting young people to enter, or remain in, education or employment. The program has achieved employment outcomes 3.4 times higher for participants in the program than for those who did not participate in the program and remained in treatment as usual [8]. Locating IPS within youth mental health services is noted as a beneficial approach in other studies [4, 8, 11, 62]. IPS has been used in conjunction with adult mental health services, also achieving better outcomes particularly with when resources or services are integrated and located together [61]. The IPS model is covered in more detail in the section below.

Findings:

- Existing employment services for people with mental disorders cost Australia more than half a billion dollars each year and are not effectively supporting people with mental disorders into work. For example, recent data shows that only 10% of people with a psychiatric disability using DES will maintain employment for six months.
- There is evidence that many people with severe mental disorders are misclassified by existing welfare assessment processes, which results in them receiving inadequate levels of support.
- Many service users with mental illness report that recovery-oriented practices were not consistently implemented within DES services, suggesting improvements could be made to better support people with mental illness to find and maintain employment.
- Studies from Australia and around the world have consistently shown that the IPS model achieves better employment outcomes than the current DES model.

The evidence

Employment contributes to recovery and improved quality of life

Overwhelmingly, the evidence shows that working as part of the recovery process is one of the most effective interventions for people with mental disorders, and even more so for those with severe mental disorders [18, 42].

Providing person-centered support that includes connecting the individual's vocational aspirations with support and flexibility to re-connect with the mainstream workforce is a critical aspect of successful programs [11, 15, 33, 36, 41]. Longer term support that provides greater flexibility and assistance with workplace and general life skills can often be critical to effectively supporting people with a mental disorder to find and retain employment [5, 18, 33]. Mainstream job seeking programs that focus on job attainment and cease shortly after placement achieve low results for people living with mental disorders [30, 61].

Despite commonly held misconceptions [16], a systematic review found no evidence that employment is detrimental to the health of people with severe mental disorders [20].

For anyone, including people living with a mental disorder, the opportunity to work in meaningful employment is one of the main determinants and indicators of health and quality of life [15, 16, 19, 20]. Employment is linked to:

- increased income and access to resources [19, 40],
- reduced welfare dependence [20],
- increased self-esteem, social identity, and status [15, 17, 18, 20, 40],
- improved social inclusion through opportunities to interact and integrate in community [5, 12, 15, 16, 18-20, 40], and
- better physical and mental health [20].

Finding:

- Employment improves mental and physical health, overall wellbeing and reduces dependency on welfare and health systems.

Addressing key barriers to employment is critical to improving outcomes

Effective approaches to lifting educational attainment among people with mental disorders improve employment outcomes

There is a strong connection between education and employment outcomes [25, 32] and the demand for workers to have post-school qualifications is increasing [63]. A recent study found young Australians who did not attain a Year 12 or equivalent qualification were more than twice as likely as their peers who finished school to be unemployed or not in the labour market at age 29 [64].

As highlighted in the previous chapter, the age of onset of mental disorders often means educational attainment is disrupted if not derailed entirely. Improving rates of school completion and post-school qualification attainment is therefore crucial to lifting employment outcomes among people with mental disorders [25, 32].

Effectively supporting improved educational attainment among people with mental disorders requires [65-67]:

- Preventative efforts to promote good mental health and healthy social and emotional development in early childhood and during the school years [65];
- Strategies to support students with poor mental health and those with a mental disorder with their health and to remain engaged in their schooling and/or tertiary studies [65, 67]; and
- Initiatives to re-engage and pathways to further education for those who leave their studies early [6, 10, 25].

Early Childhood Education and Care (ECEC) services and primary and secondary schools can play critical roles in supporting good mental health among children and young people. These include providing healthy and inclusive learning environments, and teaching that supports positive social and emotional development [68-71]. Additionally, they can help to identify issues when they arise, provide information to parents and young people about available services, provide counselling directly, or act as a gateway to external mental health services [72]. In addition to promoting good mental health, these roles are pivotal in supporting students experiencing issues with their mental health to remain engaged with their education.

While many ECEC services and schools are already providing some or all of these supports, additional expertise and demand placed on educators and their institutions needs to be recognised [72]. In many instances, teachers lack the training and knowledge to appropriately handle complex mental disorders [73], and in some instances are not equipped to effectively deliver social and emotional learning curriculum [74, 75]. Additionally, educators can struggle to navigate the large and growing number of programs, policies and frameworks related to mental health, leading to poor implementation and uptake [75, 76]. Given the increasing focus on the role of ECEC services and schools in relation to mental health of children and young people [68, 70, 71], these services need to be effectively funded and supported to train staff, implement relevant policies, and properly coordinate wellbeing support.

Promising policy - connecting with external health providers

Collaboration with external health providers can be effective in providing high quality mental health care to students.

The Victorian Government's Doctors in Secondary Schools program is one example of how embedding primary health care services within the school environment can work to improve access to healthcare [77].

As adolescent health is a predictor of the future adult health of the population, this program aims to reduce the barriers adolescents experience in accessing healthcare by bringing healthcare to the students. This is particularly important in areas that are both low socio-economic and rural as high school students are more likely to be reliant on an adult to drive them to an appointment due to distance and lack of public transport [78].

In the first year, 332 appointments were provided across 33 clinics as either scheduled or drop-in. Although reasons for appointments included routine needs for immunisations and blood tests, as well as common medical issues such as headaches and asthma, participating GPs also routinely treated other wellbeing concerns from anxiety and depression to poor sleeping. Through this contact with students, one clinic identified that the students were generally not eating enough fruit and took the initiative to provide free pieces of fruit on clinic days. Demand for fruit has increased from 32 pieces per clinic day to 50 pieces and it is hoped that initiatives such as these may positively influence long term dietary habits [78].

This program reinforces the value of co-location and the importance of GPs having training in adolescent health [77]. The program illustrates the potential of integrating health closely with education settings to improve the knowledge and resources about their health that young people leave school with, and to establish habits to maintain good health over their lifetime [78].

In addition to the supports provided in schools, it is also important to provide opportunities to re-engage young people with education. According to the Organisation for Economic Co-operation and Development (OECD), 27% of Australians with a severe mental disorders and 25% with a moderate mental disorder leave school early, compared to about 15% of young people with no mental disorder [43]. Providing pathways to ensure these young people have the option and support to re-engage with school or with equivalent vocational education is critical to improving their long-term health and employment outcomes. A review [79] of effective re-engagement models categorised key strategies around four areas:

- *Outreach* – providing easily accessible information, bringing learning to the learner, targeting high needs groups, establishing lasting meaningful relationships;
- *Wellbeing* – intensive support through guidance, counselling, monitoring and follow-up, taking a client sensitive approach to wellbeing, developing beneficial relationships within the community, the 'hubbing' of services, providing whole community or familial intervention;
- *Pedagogy* – making learning applied or hands-on, providing flexible learning options, addressing literacy and numeracy skill development needs, offering programs that integrate technologies;
- *Pathways* – embedding pathways in the intervention program, establishing connections with community and other institutions, using labour market approaches, integrating work-based learning programs with other supports.

As noted in the review, the selection of re-engagement initiatives should include consideration of how well they incorporate these strategies [79].

"Expanding access to mental health services for youth might have a net positive societal value by helping to prevent some of these adverse educational outcomes." [80]

Students living with a mental disorder who have been able to enter university are more likely to leave their course before completing it, which may have a significant impact on their future employment [81]. The Australian University Mental Health Framework [81] provides key principles and practices that can contribute to the improved mental health of university students and consequently their educational attainment:

- Mental health and wellbeing approaches should be informed by students' reality and their needs and perspectives;
- A whole of university approach is needed to support the environment that improves mental health and wellbeing of university students;
- Mentally healthy university communities foster an inclusive, diverse environment, encourage participation; support students' personal and academic achievements; and promote connectedness;
- Cooperation and coordinated actions may strengthen response to students' mental health and wellbeing;
- University students need to be able to access effective, appropriate, and timely supports and services that will meet their mental health and wellbeing needs;
- Constant evidence-informed innovations and improvements help build an understanding of effective strategies that enhance students' mental health and wellbeing [81].

Other post-secondary education and training options play an even more important role in creating pathways into skilled employment for people experiencing mental health challenges. The vocational education and training (VET) sector delivers qualifications and pathways into meaningful work for many experiencing adverse financial, social, familial or housing circumstances; all demographic groups with significant overlap with those living with mental disorders [82]. In past research, VET providers have reported mixed levels of readiness amongst staff to support students living with mental disorders [83]. Recent reports show a need for more student support in VET generally [84]. Building capacity of VET providers to respond to mental illness can lift learning outcomes and create pathways to employment [84].

The Adult, Community and Further Education (ACFE) sector is the third component of the post-secondary education and training sector, and also plays an important role in offering education and training for people who struggle in formal learning environments. ACFE providers offer diverse and flexible courses, many of which lead directly to employment. TaskForce Victoria is an example of an ACFE provider with a specific focus on vulnerable populations, including those experiencing mental disorders and substance addiction [85]. The ACE DisAbility Network also helps ACFE providers tailor their programs to people with disability, including in mental health [86].

Promising practice – supported education

Supported education (SEd) is a promising approach that can improve educational attainment among people with mental disorders [87-89]. This can help ameliorate upstream challenges that inhibit sustainable employment outcomes for people with mental disorders.

Generally designed as programmatic interventions, SEd connects people with study/training based on their preferences and aligned with their education, career, and personal goals [87]. The SEd approach aims to support academic goal-setting, build academic skills, help navigate educational settings, and improve motivation to complete goals.

While there is considerable variation in programs, including their location and configuration, SEd programs all have common key features. These include specialist staff that support [87]:

- building skills that are key to academic success
- navigating and coordinating other supports and services (e.g. education, health, enrolment, student accommodation), and
- connecting with mental health services.

There is preliminary evidence showing SEd can support improved educational attainment, although further well-designed research and evaluation of specific models is required. One model with encouraging outcomes in an Australian context is a modified version of the *Individual Placement and Support* (IPS) program. A small Victorian trial of an IPS for education program demonstrated the potential to support improved educational attainment, with around 95% of participants actively engaged with their education six months after receiving support [10]. Another small trial in NSW found 70% of IPS for education service users continued or had completed their chosen course of study [89]. This encouraging initial evidence suggests an adapted IPS for education (IPSEd) could be an effective approach to supporting young people with severe mental disorders to re-engage with education.

Given the connection between mental disorders in young people and disrupted education followed by long-term unemployment and lifetime welfare dependency [1, 6, 9-13, 20-22, 51], providing effective and supported education programs can be expected to far outweigh the short-term costs of the programs. In addition, for adults with psychiatric disabilities, support to re-engage with education can be a pathway to gaining skills and qualifications that are advantageous for securing meaningful employment.

Reducing stigma and misperceptions among health professionals and employers is key to improving employment outcomes

Stigma about people with a mental disorder often leads to discrimination and exclusion from a wide range of opportunities, including in relation to employment. *The Fifth National Mental Health and Suicide Prevention Plan* includes reducing stigma and discrimination as a priority area [90]. It sets out a range of actions to improve community understanding and reduce stigma and discrimination in the health workforce. The Productivity Commission has recommended a National Stigma Reduction Strategy [29] to be led by people with lived experience of mental disorders. Key elements include connecting people with and without mental disorders to

increase understanding, targeting messages to specific audiences and different aspects of stigma, and focusing on areas that are poorly understood by the community. It calls for a sustained commitment to reduce stigma.

Some evidence indicates that broad approaches such as mass media, educational campaigns and programs [91] (for example, the Mental Health First Aid program), are effective in improving social attitudes towards mental disorders [92]. Targeted interventions show promise, with social-contact-based interventions usually resulting in short-term improvement in attitudes in student cohorts [93, 94]. Another study found that standalone stigma reduction educational programs tended to lead to suppression, rather than reduction of stigmas, meaning that people learn to hide socially undesirable beliefs rather than changing their attitude [95]. Social media marketing also seems to effective in reducing stigmas of mental illness [93]. However, the limited information available on long-term follow-up [96] makes it difficult to draw conclusions as to the most effective approaches for creating sustained change [97]. Further research is required to establish the role of mass media in reducing discrimination [91] and identify effective workplace interventions.

As two critical groups, healthcare workers and employers, are consistently noted as either holding misperceptions or lacking important knowledge about how to support people with mental disorders in the workplace [6, 20, 22-24, 55, 56], interventions that target these two groups and provide practical tools and resources may create greater and longer lasting change. As illustrated in the box below, vocational staff are one example of how this can be achieved.

Promising policy – employment specialists breaking down barriers

Trials of IPS show that the use of specialised vocational staff, trained in the IPS model [15], are effective in helping to reduce stigma as well as providing support to re-engage with the workforce. This in turn improves job seekers success in maintaining employment for longer [15].

Employment specialists are integrated within an individual's mental health team [15, 36, 40]. They work closely with the clinical staff to break down barriers and improve understanding of the value of vocational support in a person's recovery and provide the co-ordination point into the employment and educational systems that mental health practitioners can find difficult to navigate [23]. Locating vocational staff within mental health centres appears to be an effective approach that should be expanded [32].

Vocational specialists also play an important role in reducing stigma and providing support in the workplace [17, 25]. They are able to provide agreed supporting information to employers [25, 98] and more broadly maintain relationships with industry and wider community [25, 32, 40] so that the individual has greater support in the workplace. This assists with breaking down the negative misperceptions that lead to stigma and discrimination commonly experienced by people with a mental disorder [6, 22, 26].

Programs, such as IPS, that provide this type of support for longer, even at a reduced level, demonstrate improved long term employment outcomes [41].

Integrated models have proven effective in Australia and are easier to navigate

In Australia, following submissions from a variety of researchers, industry, stakeholders and people with lived experience, both the recent Productivity Commission inquiry into mental health and the Royal Commission into Victoria's Mental Health System recommended better integration of healthcare with other systems, such as employment and welfare [6, 24, 28, 29]. Closer integration of health and employment services would improve the navigability of services [25, 28, 30]. Integration of these services is linked to better outcomes for service users as well as increased system efficiency [99]. Working with professionals from different sectors can increase staff competencies [99], and as noted above, can break down misconceptions about the role of employment in recovery [5, 6]. Integrated services can also enable better coordination and continuity of care [99].

The youth mental health organization, *headspace*, provides an Australian example of the efficacy of integrated care. Joining up services around an individual has been shown to improve mental health outcomes [7, 8, 11, 25, 62, 99]. Benefits include significantly reduced distress levels, smaller reductions in suicidal ideation and self-harm behaviours, and improvements to school or work engagement, confidence and self-esteem [7]. Structural arrangements that are identified as contributing to the improved outcomes achieved in the *headspace* model include:

- Integrated services provide a one-stop-shop for young people to access psychological support as well as help with other areas, including sexual health and study skills, from trained mental health professionals adept at working with young people [8, 11, 25, 62].
- Removal of barriers to access that include walk in appointments, no referral required, no parent / guardian required, and no out-of-pocket expenses [8, 11, 25, 62].

The increased use over time of *headspace* (and similar services overseas) by young people under 25 indicates models providing integrated care are popular [7]. It shows how effective these models are in removing barriers to accessing care and improving the navigability of services [8, 11]. The quality of care and patient outcomes are improved by providing more holistic support to meet more of the needs of young people, rather than focusing on single symptoms or issues [8, 11, 25, 62]. Importantly, the model has helped reduced stigma about seeking help [7, 8, 11, 25, 62]. Although IPS has been integrated with success in with adult mental health services multiple times over the past 15 years, this has not been at the same pace as youth services [37].

Findings:

- Improving employment outcomes requires interventions that
    - improve educational attainment by supporting young people living with mental disorders to stay in school or re-engage with vocational education
    - reduce stigma about mental disorders in workplaces and health services
    - ensure adults are included in expansion of successful models
    - ensure services are integrated, co-ordinated and straightforward to access.
- Interventions that provide co-located and integrated services are effective in reducing barriers and stigma. For example,

- integrating education and health services, through programs such as Doctors in Schools and *headspace* centres, have been shown to improve access for young people by reducing barriers to using services
- IPS vocational specialists integrated in mental health teams are considered to have reduced stigma by educating and supporting health staff and employers.

Individual Placement and Support has been proven to more effectively support people with mental disorders to work and thrive

The employment services model that has proven effective in achieving high quality and sustainable employment outcomes is the IPS program [5, 8, 10, 15, 17, 19, 21, 33, 34, 36, 40, 42, 100, 101]. The IPS program has a 'place – train' focus [6, 17, 29]. The IPS model originated in the United States in the early 1990s [88]. It integrates employment and vocational support with mental health and non-vocational support [88]. It focuses on the individual and their employment aspirations and on rapid competitive employment placement [12, 16, 33, 36, 41, 88].

Figure 10 represents the eight principles of the IPS program. These include the ability for people to self-refer for employment support, connecting people with work that aligns with their vocational aspirations, providing them with customised and time unlimited support, and support to assist employers understand fluctuating impacts of mental disorders [8, 33].

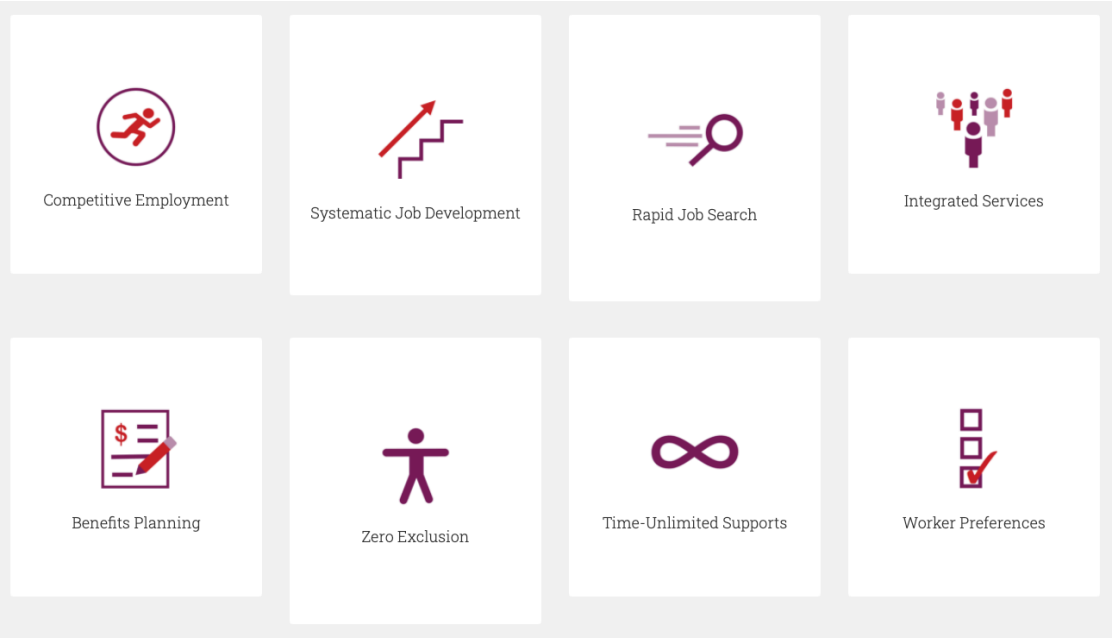

Figure 10 - Eight Principles of IPS

Source: Reproduced with permission from the IPS Employment Center [102]

This program has been rigorously researched over several decades in a variety of countries and regulatory contexts, including successful trials in Australia [34]. Evidence from these studies demonstrate that employment helps recovery and that the IPS model gets better long-term employment results when compared to other employment services [8, 12, 15, 19, 33-36]. Australian trials have achieved employment results for participants at 71.2%, compared to 48% for non-participants [8]. Figure 11 compares results of IPS in international trials showing better

outcomes over the control groups are consistently achieved, with some variation between different mental disorders [34].

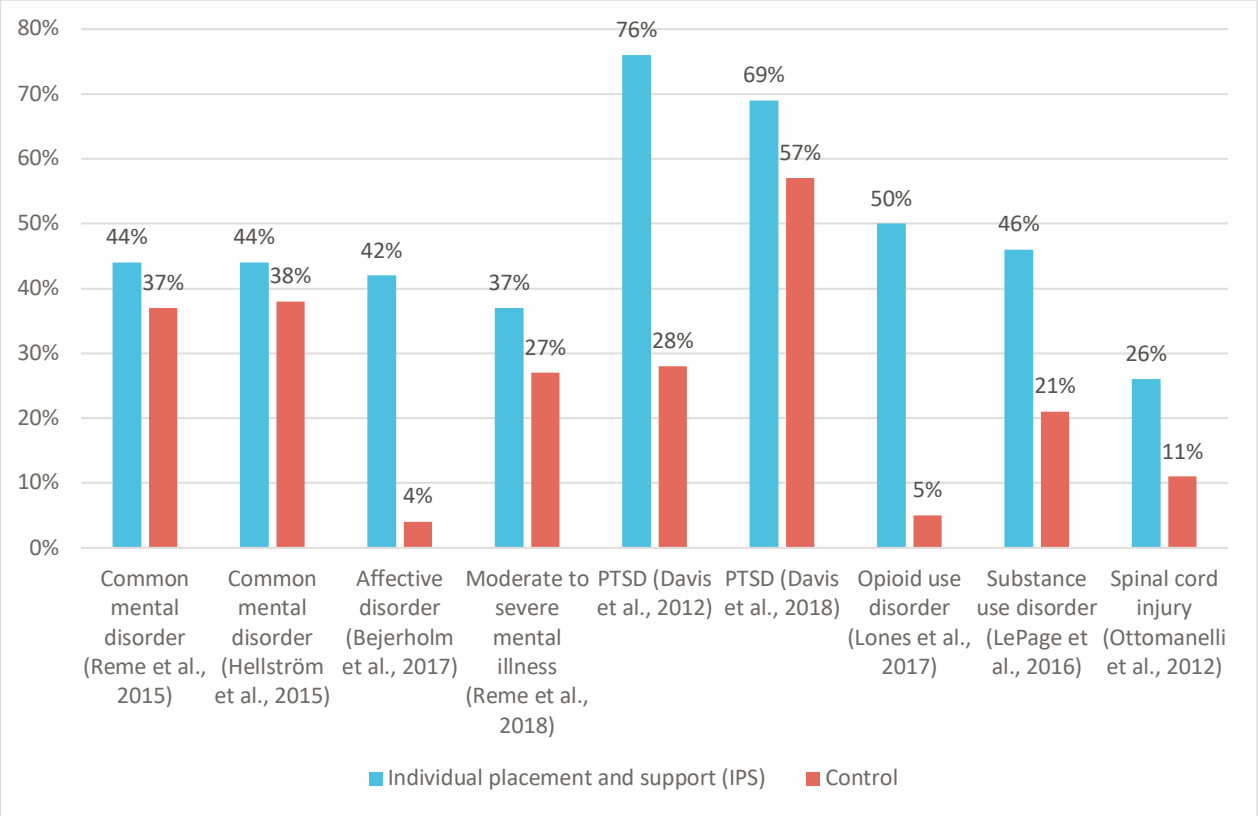

Figure 11 - Competitive employment rates during follow-up among recipients of IPS with a condition other than serious mental illness and a control group, by study

Source: Bond et al, 2019 [34]

IPS programs are now located in 24 *headspace* centres across Australia, with the program funded in the 2020-2021 budget to expand by a further 26 locations, to a total of 50 [103, 104]. This model locates IPS vocational staff within the one-stop-shop *headspace* mental health centres [103] for youth and young adults. Vocational staff are expected to have an understanding of the local youth population and their needs [13] as well as the ability to work sensitively to improve employers' knowledge and capacity to support employees with mental disorders as they re-engage with work [25]. In addition, some DES providers offer IPS programs by seconding an IPS vocational specialist to community mental healthcare services [29]. There are 53 full-time equivalent IPS vocational specialists employed through this partnership program [29]. Although the uptake by DES participants to date is low [29], integrating a vocational specialist within mental health services has been considered a more practical approach than locating a mental health worker in an employment service [32]. A further $5.7 million has been added in the most recent federal budget to trial an expansion of IPS to make it available to adults [104].

Research into IPS has shown a wide variety of health-related benefits in addition to improved employment outcomes. Trials of the model have shown participants improved their functioning [18] and personal wellbeing [18, 20]. Importantly, trial participants used mental health services [15, 17], hospitals [15] and psychiatric treatments less often [20], had shorter, less costly hospital stays [5, 19], and generally were considered to have reduced clinical symptoms [18]. Those who combined supported employment with other cognitive behavioural therapy had

fewer depressive incidents [5]. Supplementing with other additional techniques, such as motivational interviewing and apps that promote self-management, also shows promise [105, 106]. It is estimated that supporting people with a mental disorder into employment using these programs resulted in reductions in the use of treatment services estimated between 25% and 50% [5]. This demonstrates that, when provided with the right level of support, people with a mental disorder can not only find, but also retain work, and benefit from improved health [16]. Additionally, the evidence indicates that remaining in employment contributes to reduced use of specialized mental health services [6], reliance on emergency department use for mental health conditions [38] and improved physical health outcomes in general [38].

The IPS model provides a systemized framework that can, and has been, replicated in other countries and in Australia with consistent results to achieve longer term employment for people with mental disorders. Adding IPS into *headspace* mental health services has demonstrated the capacity for and benefit of integrating vocational rehabilitation into the mental health care plans of individuals by removing barriers and providing effective individualized supports.

As well, the Productivity Commission found that the IPS model would likely achieve net savings to government, increase income for participants substantially, and increase participants' quality of life [29].

The Productivity Commission found providing IPS employment supports to 40,000 people for a year would:

- cost between $108-286 million
- result in healthcare savings of $137-575 million
- result in savings to DES of about $49 million
- increase participants' income by $42-90 million
- increase participants' quality of life by 238-434 quality-adjusted life years [29].

Implementation Challenges

Implementation of the IPS model within the Australian network of health, education and employment services would need to address a number of challenges.

This includes the complementarity of employment services with mental health services, particularly access and eligibility and funding arrangements to ensure that current barriers and provisions relevant to these programs are not imported or imposed on the integrity of implementation of the IPS model.

Implementation must support fidelity with the eight principles of IPS, which underpin the effectiveness of the model. National implementation of the IPS Fidelity Scale would enable standardized assessment of providers' performance to support this aim [107]. As detailed by the Productivity Commission, routine audits, monitoring and evaluation would also help to ensure effectiveness as the program expands, including through enabling identification and support for underperforming services [108]. Formal channels for nationwide systematic data collection will also be key to ensuring best practice is promoted[108].

Implementation would need to ensure that funding arrangements and contractual obligations do not compromise the flexibility, adaptability and continuity of the service provision to individuals and do not impede the professional status and effective integration of vocational specialists with mental health specialists [32].

A national rollout of IPS would additionally require a complementary workforce strategy aimed at meeting the increased demand for skilled IPS specialists [107]. The Productivity Commission notes that any rollout of IPS would need to be staged and include a plan to train staff, noting that two years' experience was often required to develop an IPS skillset [108].

To effectively scale up the provision of IPS services would require adaptation of existing funding and service arrangements including:

- Government level:
    - Funding systems – different levels and departments within government are responsible for health and employment;
    - Mutual obligations – these are requirements associated with the *jobactive* and Youth Allowance welfare payments and may not align with the IPS program principles;
    - Outcomes based funding used in employment services may not fit with IPS principles.
- Industry level:
    - Small caseload management associated with IPS services may conflict with larger caseloads more common in DES providers;
    - Potential for difficulties integrating employment and health specialists due to different cultures, systems and performance outcomes;
    - Lack of availability of skilled vocational staff and mental health services in regional and remote areas.

Findings:

- IPS is the most effective model for supporting people with mental disorders into employment.
- Policy options need to remove implementation barriers to effectively achieve meaningful employment outcomes for people living with mental disorders.

Policy Options

National mental health policy aims to link mental health services to other services such as housing, social support, income security, employment, and training and to general health services and support. The Fifth National Mental Health and Suicide Prevention Plan (2017-2022) has established an indicator of the proportion of people with mental illness in employment as an outcome of the Plan [90]. The Plan says that greater integration between mental health, health and other services is required, with better recognition of the broader determinants of mental health and issues that affect people living with mental illness. This requires connections between health and areas such as education and employment, and expansion of integration into prevention and early intervention.

The Productivity Commission has recommended a national, whole-of-government approach to reform the governance and effectiveness of mental health services and supports [109].

A nationally consistent implementation strategy to achieve these outcomes is lacking.

The policy options for effective national implementation of an integrated multi-sectoral approach supporting people with mental disorders to engage in education and employment that emerge from the evidence are:

1. **Establishment of a National Mental Health Individual Placement and Support Scheme**

As with the implementation of the IPS model within *headspace*; implementation of an integrated model of health, education and employment support for people living with mental disorders at all ages and throughout Australia's communities would require:

a) National centre of excellence - To support high fidelity in employment support services, a national IPS centre of excellence should be established. The centre would create guidelines and quality standards, collect data across the program and participating centres, report and provide public accountability for services. It should support training and professional development, and work with community mental health services setting up an IPS employment service. This centre should be funded to provide training and professional development to employment specialists hired within community mental health services. This should include development of materials to support vocational specialists such as a toolkit to support employers with practical advice on workplace adjustments and accommodations.

b) Integration of vocational education and employment specialists with either:

   - Specialist mental health services (community mental health services; area mental health services) or
   - Public sector regional mental health support services or regional primary care support services (Primary Health Networks)

c) Mental health care plans and reviews of plans to provide for referral to vocational education and employment specialists, noting the need to preserve the zero-exclusion principle that is key to IPS program fidelity;

d) Individual Placement and Support to be funded through dedicated program funding for mental health services with integrated IPS vocational specialists.

e) IPS and IPS(Ed) regional services to be established as regional services integrated with health and education service providers within the region and to provide information, education, and support to:
    - healthcare professionals and services
    - Early Childhood Education and Care (ECEC) services, schools, and tertiary institutions

2. Early intervention services for mental health support with education

A whole of government approach for improving educational outcomes for people living with mental disorders, including exploring options to:

a) Collocate health services, including mental health support, in education settings – this could comprise national implementation through Australia's 31 Primary Health Networks of primary care medical and nursing services to schools, modelled on the Victorian Doctors in Secondary Schools program.

b) Employ health and wellbeing specialists in education settings – in response to the increasing focus on health and wellbeing in education settings, governments should explore options to employ qualified health and wellbeing professionals in ECEC services and schools to ensure high quality implementation and coordination of relevant and growing number of services, frameworks and policies.

c) Pilot and evaluate IPS for education – Given preliminary evidence regarding the efficacy of IPS for education, governments should explore options for piloting larger scale IPS(Ed) for education services with appropriate high-quality evaluation. This should aim to support people with mental illness and low levels of education to re-engage with education in order to gain the skills to pursue meaningful employment.

Both these policy options would require a complementary plan to develop the necessary workforces. This includes training vocational specialists with adequate time to gain relevant experience as well as training and supporting the relevant wellbeing roles in ECEC, schools and tertiary institutions.

Whilst these recommendations are made at a time of significant pressures on health and education workforces, following the COVID-19 pandemic impacts, they are recommendations which will address significant pressures on those working within employment and education services where mental health needs and difficulties of client groups are hard to address without appropriate specialist training, support and service models.

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