National Survey of Mental Health and Wellbeing
Bulletin 3

Employment and psychosis

A Bulletin of the Low Prevalence Disorders Study

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**Low prevalence component of the survey:**
- People living with psychotic illness: an Australian study 1997-1998
- People living with psychotic illness: an overview (Bulletin 1)
- Costs of psychosis in urban Australia (Bulletin 2)
- Employment and psychosis (Bulletin 3)
- The use of psychopharmacological and other treatments by persons with psychosis (Bulletin 4)
- Disability, homelessness and social relationships among people living with psychosis in Australia (Bulletin 5)
- Stigma and discrimination (Bulletin 6)

**Child and adolescent component of the survey:**
- The mental health of young people in Australia
- Adolescent depression (Leaflet 1)
- Conduct disorders (Leaflet 2)
- Adolescent suicide (Leaflet 3)
- Attention deficit / hyperactivity disorder (Leaflet 4)
Foreword

Individuals with psychiatric disability only began to access employment related services following the 1991 Commonwealth-State Disability Agreement. The employment related programs developed in the 1980’s and early 1990’s did not focus on psychiatric disability. In fact these individuals were specifically excluded in legislation until 1986. This was despite the fact that between a fifth and a quarter of persons in receipt of Commonwealth income security were disabled by virtue of a psychiatric condition. Quite apart from the discrimination evident in this exclusion, it was an odd policy alignment to have such a large group of people denied access to programs designed to help remove people from dependence on welfare. The further disadvantage arising from the late attention to people with psychiatric disability has been the design of the programs. Employment programs were largely designed for people with physical, sensory or intellectual disability and did not cater for the specific needs of those with psychiatric disability.

Throughout the 1990’s there have been changes to the disability services programs. Momentum has grown to have people with psychiatric disability receive equitable access to these programs. However equitable access to programs that are not designed for the specific needs of people with psychiatric disability is not likely to result in optimal outcomes. As the result of initiatives funded under the National Mental Health Strategy we now have a much better information base with which to design these programs. This report draws on new information from the Collaborative Study on Low-Prevalence (Psychotic) Disorders and makes 20 recommendations for how the programs can be improved. The policy implications of these findings cannot be ignored.

Psychosis is one of the most disabling of all mental disorders. It therefore provides challenges for consumers, their carers, and those professionals working to help individuals with psychosis return to the workplace. It is imperative that our systems of care rise to meet these challenges. Not only will clinical outcomes be improved, but the quality of life for people with disability will be enhanced if they are able to gain a level of remunerated employment commensurate with their vocational potential. The lost productivity that occurs as a result of ill health, including mental illness, has economic as well as personal and social costs. The recommendations contained in this report give clear directions for Australia in the delivery of programs for people with psychiatric disability. Implementation of the recommendations in the report will create the potential for an inclusive and effective system of employment services that I believe will benefit not only individuals and their families but also the broader community.

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1. Introduction

The value of work as a component of normal, healthy existence is well understood. For people with severe mental illness, such as the psychoses, employment can assist recovery as well as provide an opportunity to contribute to the economic and social well-being of society. Mentally ill people who obtain employment achieve better symptom control, greater self-esteem, higher levels of satisfaction and more financial security (Mueser et al., 1997a). With the introduction of the Disability Reform Program in 1991, the Commonwealth Government implemented a range of initiatives to improve the workforce participation of people with a disability. People with psychiatric disabilities were initially accorded a low priority (Whiteford et al., 1993) and although a review of the Disability Reform Program in 1995 (Working Solution: Baume and Kay, 1995) recommended substantial changes, the participation rates have failed to mirror the known prevalence of the various disability groups. The first trial of case-based funding commenced in November 1999 and reported a significant improvement in the participation rate of people with a psychiatric disability but without a commensurate improvement in employment outcomes. In a period of relative economic prosperity, the failure to achieve higher employment rates carries the risk that mental illness and unemployment will be viewed as synonymous. The current trials of case-based funding are a positive initiative. However, if they remain isolated and not linked to a network of rehabilitation, support and employment options that transcend State and Commonwealth jurisdictions, the probability of achieving significant improvements in the quality of life of people with psychiatric disabilities through employment will remain low.

1.1 Impact and effects of psychosis

Mental disorders are common and constituted five of the ten leading causes of disability worldwide in 1990 (Murray and Lopez, 1996). In Australia mental disorders account for 13.3% of the burden of disease and schizophrenia, with a prevalence of less than 5 per 1000, accounts for more than 5% of disease burden due to mental disorders (Mathers et al., 2000). The lifetime risk of developing a psychotic disorder such as schizophrenia, lies between 0.5% and 1.72% (WHO, 1992) and the annual prevalence of psychosis in Australia is 4-7 per 1,000 (Jablensky et al., 1999). Of those who develop a psychotic disorder, more than 50% will do so between the ages of 15 and 24 years (Jablensky et al., 1999). For young people, the co-occurrence of mental ill health and substance misuse carries with it an increased risk of suicide and self-harm, thereby multiplying the illness burden.

Mental disorders such as schizophrenia and other psychoses are heterogeneous and are characterised by varying profiles of illness and outcomes. Studies of the long-term course of schizophrenic disorders suggest that outcome appears to be better than previously thought. Between 45% and 66% of people with schizophrenia were found to have either fully recovered or were only mildly impaired at follow-up, on average 20 years after initial contact (Bleuler, 1972; Ciompi, 1980; Harding et al., 1987a, 1987b). More recently Mason et al. (1995) found that over a thirteen-year period 49% of the patients studied were either in complete remission or only suffered mild symptoms. Slightly more than 50% were without negative symptoms (eg, affective flattening, apathy, asociality) and had good or fair social functioning. However, unlike chronic physical disabilities, people with mental illness endure considerable variations in their level of functioning. Periods of good functioning can be replaced by periods of poor functioning and vice versa, although the relationship between symptoms and specific domains of functioning remains unclear. For example, a person with prominent symptoms may be able to work effectively, whilst others with fewer symptoms are unable to maintain role functioning (McGorry, 1992).
1.2 Effects of employment on people with psychotic disorders

Evidence attesting to the positive impact of employment on a range of non-vocational domains of functioning has been steadily accumulating. In a longitudinal study of people with severe mental illness, Mueser et al. (1997a) found that participants who were in employment after 18 months tended to have lower symptoms (particularly thought disorder), higher Global Assessment Scores, better self-esteem and more satisfaction with their finances and vocational services than those who were unemployed. In a review of four models of psychiatric rehabilitation, Baronet and Gerber (1998) concluded that being in employment was associated with an increase in independence, an improved sense of self-worth and an improved family atmosphere. Lysakar and Bell (1995) found a significant improvement in social skills after 17 weeks of job placement. In a study of paid sheltered employment, Bell et al. (1996) found that employment resulted in significant symptom improvement and fewer hospitalisations. In spite of these results, access to employment opportunities for people with psychiatric disabilities remains problematic, with most dependent on social welfare support.

1.3 Disability support and psychosis

Between 1970 and 1998 the proportion of workforce-aged Australians receiving income support increased fourfold, with expenditure rising from 0.6% to 3.3% of Gross Domestic Product (Interim Report of Reference Group on Social Welfare, 2000). In 1998, 2.6 million workforce-aged people were receiving social security payments. Excluding payments to full-time students, 21% or 600,000 of the population receiving income support were on a Disability Support Pension (DSP). Estimates suggest that by 2006 this will have increased to three-quarters of a million people (Newman, 2000). Two-thirds of those receiving the DSP were aged between 45 and 65, with about one-fifth of the disability support pensioners receiving support payments for more than 10 years. The majority had been on the pension for life, with only 8% earning income from other sources (Newman, 2000). The second most common medical condition for which people received a DSP was ‘psychological/psychiatric’ (approximately one-fifth).

Mental health and employment status data were identified from the records of interviews conducted on 980 individuals in the Low Prevalence Disorders Study (LPDS), a national study conducted in predominantly urban catchment areas of the Australian Capital Territory, Queensland, Victoria and Western Australia between 1997 and 1998 (Jablensky et al., 1999, 2000). The LPDS participants were identified using a census-based approach and interviews were undertaken using a specially designed instrument (Diagnostic Interview for Psychosis) covering demographic details, living circumstances, symptoms, level of disablement and service utilisation. The majority (85%) of people with psychosis in the LPDS were dependent on a government pension or social benefit (Table 1), with more than half unable to describe any main occupation in the past 12 months (Jablensky et al., 1999).
Table 1  Government benefits received

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Pension</td>
<td>0.2</td>
<td>2.5</td>
<td>1.1</td>
</tr>
<tr>
<td>Service Pension</td>
<td>0.3</td>
<td>0.5</td>
<td>0.4</td>
</tr>
<tr>
<td>Disability Support / Invalid Pension</td>
<td>72.4</td>
<td>62.2</td>
<td>68.3</td>
</tr>
<tr>
<td>Widow's Pension or Wife's Pension</td>
<td>0.3</td>
<td>1.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Carer's Pension</td>
<td>0</td>
<td>0.3</td>
<td>0.1</td>
</tr>
<tr>
<td>Sole Parent's Pension</td>
<td>0.2</td>
<td>2.0</td>
<td>0.9</td>
</tr>
<tr>
<td>Sickness Allowance / Benefit</td>
<td>4.8</td>
<td>4.8</td>
<td>4.8</td>
</tr>
<tr>
<td>Newstart / Job Search / Mature Age Allowance</td>
<td>7.7</td>
<td>4.8</td>
<td>6.5</td>
</tr>
<tr>
<td>Unemployed Benefit</td>
<td>4.4</td>
<td>3.0</td>
<td>3.9</td>
</tr>
<tr>
<td>Special Benefit</td>
<td>0.3</td>
<td>0</td>
<td>0.2</td>
</tr>
<tr>
<td>Other</td>
<td>2.2</td>
<td>3.8</td>
<td>2.9</td>
</tr>
<tr>
<td>Not on a benefit, or not known</td>
<td>10.1</td>
<td>17.5</td>
<td>13.1</td>
</tr>
</tbody>
</table>

*Note that percentage figures may add to more than 100% as some participants were receiving more than one benefit.

1.4 Summary

The psychoses contribute substantially to the burden of disease due to mental disorders. Employment for people with psychoses has the potential to reduce symptoms, enhance self-esteem, reduce disability, improve independence and provide an overall better quality of life. However, the majority of people with psychotic disorders remain dependent on government pensions and other benefits for many years. Their dependency and unemployment represents not only a large cost to government but a huge cost to society and individuals at both the financial and personal levels. People with psychotic disorders more often than not find themselves marginalised, coping with poverty and social disadvantage for almost their entire adult lives.
2. Barriers to employment

Employment is not only a necessary condition for truly independent community living but also a platform from which people with chronic mental illness can obtain the rewarding aspects of mainstream living that most people take for granted (Yankowitz, 1990). In a survey of 500 people with a chronic mental illness, Lehman et al., (1983) found that the lack of work was one of the greatest complaints related to poor quality of life. The Report of the National Inquiry into the Human Rights of People with Mental Illness (Human Rights and Equal Opportunity Commission, 1993) identified barriers preventing people with psychiatric disability from securing work compatible with their abilities and interests. These comprised lack of access to vocational and educational training, the debilitating effects of psychiatric symptoms and treatments, and job design. Other factors include scarcity of employment opportunities, low vocational and employment expectations of mental health staff (Graffam & Naccarella, 1997), limited State and Commonwealth collaboration, increasing emphasis on productivity, lack of suitable work histories and high minimum wages. Limited access to community services (housing, public transport etc.), unfavourable community and employer attitudes, particularly as they impact on workplace disclosure, may also affect employment outcomes (Commonwealth of Australia, 1993; Spillane, 1999).

2.1 Role of the Commonwealth Government

Following the introduction of the Commonwealth Disability Services Act and the Commonwealth-State Disability Agreement, the Commonwealth assumed responsibility for all disability groups. Considered a turning point by some disability organisations, the funding for or access to support services for people with psychiatric disabilities did not match the recognition accorded in the legislation (Whiteford et al., 1993). The Disability Reform Program was introduced in the 1990-91 budget with the aim of improving 'the participation of people with disabilities in employment, education and training activities...', particularly those with significant disabilities (cited in Working Solution: Baume and Kay, 1995). The Invalid Pension and the Sheltered Employment Allowance were replaced by the DSP and incentives to return to work were introduced. Funding was also allocated for the development of vocational services specialising in psychiatric disability.

Four years after the introduction of the Disability Reform Program, participation rates of people with a disability were not consistent with the known prevalence of various forms of disability (Working Solution: Baume and Kay, 1995). Seventy-three percent (18,975) of people accessing services had an intellectual disability compared to only 10% (2,653) with a physical disability, 7% (1,697) with psychiatric disabilities, 6% (1,485) with sensory disabilities and 2% (582) with acquired brain injury. The distribution of those with a psychiatric disability across the options of open, supported and sheltered employment was 24%, 18% and 58%, respectively.

The Working Solution Report recommended a fundamental shift in the provision of services and proposed that: funding should be linked to the individual and not the service; funding levels should be linked to the assessed support needs of the individual; and funding should enable flexibility and innovation. The Report also recommended that access to the system should be fair and equitable, and based on clear eligibility criteria. Hitherto, access had been dependent on ‘luck, serendipity and the presence of powerful advocates’ (Working Solution, p83). The establishment of an easy-to-use assessment protocol to determine eligibility and initial funding of support needs was recommended.
2.2 Current system: the Service Funded Model

The Commonwealth maintains a dual pathway system for job seekers with a disability wishing to enter the workforce: the Job Network and the Department of Family and Community Services (DFaCS) funded services, including supported and open employment. To determine the level of employment assistance required, Centrelink uses two assessments, the Job Seeker Classification Index (JSCI) and the Work Ability Tables (WATs). The WATs were originally introduced in late 1997 by the then Department of Social Security to determine eligibility for the DSP. The JSCI functions as an initial screening tool, determining the level of employment assistance required and special need requirements. A WATs is indicated if the impact of the job seeker’s impairments on their ability to work precludes unsupported open employment for 30 or more hours per week. The WATs is based on the assumption that a small number of core work abilities are fundamental for successful participation in the workforce. Regardless of the type of disability or impairments, the WATs assumes that the net effect on the core abilities is the same and the impact on the individual’s work performance would be relatively constant over a two-year period (Disability Industry Reference Group [DIRG], 1999). A cut-point of 50 is utilised, with those scoring above 50 assigned to the D FaCS funded services, and those scoring below 50 assigned to the Job Network. The Job Network provides three levels of support: Job Matching (Flex 1), Job Search Training (Flex 2) and Intensive Assistance (Flex 3). Despite a rigorous selection process, extensive trials, stakeholder consultations and substantive reviews, the utilisation of a streaming tool remains contentious.

2.2.1 Problems in methods of assessment for the workforce

Although the WATs were introduced with the intention of making access more equitable, it has been argued that the assessment discriminates against people with episodic conditions and fluctuating levels of disability such as occur in mental illness. Lobbyists for people with a psychiatric disability have suggested that the WATs provides what is essentially a cross-sectional assessment, tending to weight individual impairments on presentation rather than within the context of changing patterns and levels of disability. For Centrelink and specialist disability employment services, the determination of a streaming decision using the WATs is, in part, dependent on information collected from a relevant professional (usually the general practitioner) and the individual job seeker. This raises two issues in regard to the validity of the determination. Firstly, the assessor must decide how the cognitive impairments and symptoms associated with the disorder, as well as the change in role functioning, will impact on the individual’s ability to work. Certain areas of cognitive performance, such as executive functioning, working memory, verbal learning and memory, and vigilance are associated with vocational functioning in schizophrenia (McGurk and Meltzer, 2000). It is very difficult in individual cases to determine exactly whether and how such deficits and changes in symptoms will influence work capacities. Secondly, people with a mental illness frequently carry the burden of disclosure and may choose not to disclose to a stranger, even at the risk of being disadvantaged. Even when the job seeker decides to disclose, the validity of the information may not be reliable, with some individuals overstating and others understating their work skills. The considerable tensions that may arise between the Government’s need to know and the individual’s right to privacy may not be easily resolved (DIRG, 1999).

Thus, the means by which streaming decisions are made have, at best, questionable reliability. Although the Final Report of the Reference Group on Welfare Reform (2000) has recommended that the streaming process should be aided by the adoption of more sophisticated profiling tools, it is likely these will build on the two existing tools, the JSCI and the WATs. Groups such as the Western Australian Association for Mental Health (1999) have argued that the failure to adequately assess the impact of impairments on vocational and social functioning has...
resulted in people with a psychiatric disability being inappropriately directed into the Flex 3 component of the Job Network system. According to the Australian Institute of Primary Care (cited in: DIRG, 1999) inappropriate streaming decisions are very difficult to overturn. These decisions also burden the disabled person with having to meet the activity requirements of Newstart allowance. Apart from the fact that 20% of disabled people, with an average WATs score of 37, were streamed into the Job Network (DIRG, 1999), little is known of the outcomes in this pathway, particularly for people with psychiatric disabilities.

2.2.2 Outcomes of current practices

Data from the Disability Services Census 1999, indicated that the majority of people with a psychiatric disability who accessed DFaCS funded services were assisted in open employment. The WATs score for this group was, on average, very similar to the system average of 76 (DIRG, 1999). Groups with non-episodic conditions such as intellectual disabilities scored, on average, slightly below the mean. Curiously, 76% of people with a primary intellectual disability accessed assistance through supported employment services, whilst the majority (75%) of people with a psychiatric disability were assisted through open employment services (Disability Services Census, 1999). These data tend to suggest that people with a psychiatric disability are being directed into open employment, not because of their level of workability (as defined by the WATs), but due to the lack of available positions in specialist supported employment services – an outcome that possibly reflects DFaCS’s long history of providing employment services for people with intellectual disabilities.

The low participation rate of people with psychiatric disability may be a consequence of the lack of suitable positions. Across the 967 funded disability support service outlets only 15.7% or 6,410 people reported having a psychiatric disability (Disability Services Census 1999). This constituted only a slight increase from 1997 (13%) and 1998 (15%). Since 1995, the distribution in relation to prevalence has not changed significantly, with intellectual disability representing the largest group with 53.6% or 21,872, followed by psychiatric and physical disabilities (12.9%). Although the choice to work has been a voluntary decision, the minimal increase in uptake of disability groups other than intellectual disability would suggest that there are considerable disincentives to workforce participation for people with psychiatric disabilities.

Most people with psychiatric disabilities want to work, with more than two out of every three persons with severe and persistent mental illness expressing an interest in obtaining paid employment (Rogers et al., 1991). However, it appears that the least disabled are encouraged to participate, whilst those with more severe disabilities are not. This conclusion is supported by the Disability Services Census itself, which indicated that people with a primary psychiatric disability were less likely to need assistance with activities of daily living, a view markedly at variance with the high rates of reported difficulties with self-care and daily living skills in people with psychotic disorders (Jablensky et al., 1999).

2.2.3 Summary

The current service funded model is hampered by assessment methods that are not sufficiently sensitive to the particular needs of the mentally ill, and do not adequately evaluate changing levels of impairment and disability. This, together with factors such as a shortage of suitable positions, probably contributes significantly to the low rate of workforce participation by people with severe psychiatric disorders.
2.3 Case based funding model

The reform agenda introduced by the Commonwealth Government in the 1996-97 budget suggested that funding should be shifted from block service grants to a case based funding arrangement. The aim was to enhance job seekers’ access and choice, improve outcomes, make funding arrangements more equitable, provide assistance to as many as possible, and promote flexibility and innovation. In the first trial of case based funding, participants were streamed using the WATs, with funding allocated on the basis of the JSCL. The disabled person was classified into one of three funding bands, with Level 3 being the highest level of support. The funds in each band were distributed across three phases of ‘employment’, namely commencement, outcome and maintenance. In the commencement phase the service provider was required to develop an employment assistance plan. An outcome was defined as employment for a minimum of 8 hours per week. Maintenance payments were for the purchase of support to maintain the disabled person’s employment.

2.3.1 Outcomes of the case based funding model

In March 2001, data released for the first round of case based funding indicated that although the participation rate of people with a psychiatric disability had dramatically increased, it was unaccompanied by a commensurate improvement in employment outcomes (Case based Funding Trial – Phase One Statistical Update at 30 March 2001). Some 3,097 individuals participated in the funded trial in which people with a psychiatric disability represented 30.6% (949) of the overall sample. Physical and intellectual disabilities represented 22.6% (699) and 21.1% (655), respectively. In terms of employment outcomes, people with a psychiatric disability fared very poorly in relation to the other two large disability groups. Only 532 or 17.2% of all people with a disability gained employment prior to March 30, 2001. Of this group 27.5% had an intellectual disability, 24.2% a physical disability and 20.5% a psychiatric disability. Within each disability group employment outcomes were highest for people with an intellectual disability (23.4%), followed by physical (17.7%) and psychiatric (12.0%). Of those suspended from the Trial, 235 or 44.5% of all suspensions were of people with a psychiatric disability. The reasons for the suspensions were predominantly ‘disability/medical’ (39.9%), followed by ‘personal reasons’ (26.1%), with the majority being suspended after 6 months of employment assistance. Of those who exited the system, people with a psychiatric disability comprised almost one-third (179 or 32.2%). This was the largest group, followed by people with a physical disability (103 or 20.2%), with the majority of job seekers exiting the Trial in the first eight months. With a combined suspension and exit rate almost double that of the next highest group (physical), it is likely that this poor outcome for people with a psychiatric disability is more attributable to inadequate assessment of employment assistance requirements, inadequate preparation, too rapid an entry into the job network or a lack of specialist support, rather than any inherent quality of mental illness. Although preliminary, this outcome also lends weight to the possibility that the system that is attempting to improve employment outcomes may, in fact, be discouraging the participation of many people with psychiatric disabilities.

The second round of case based funding trials was modified to include additional levels of support, one of which was aimed at assisting people with very high support needs. Four levels of maintenance funding have also been included with access determined by a maintenance classification process. Although these changes were designed to strengthen the case based funding approach, people with
a psychiatric disability had consistently lower outcome rates and higher suspension and exit rates (Case Based Funding Trial – Interim Report: Executive Summary, 16 May 2002). Without the development of a model of service delivery that links mental health rehabilitation and support, and vocational rehabilitation and employment agencies across a broad range of service options, it is unlikely that the full capacities of people with a psychiatric disability will be realised. It should be emphasised that developmental disability employment models are not appropriate for people with a psychiatric disability. For people with episodic conditions the process of gaining employment is not usually characterised by a ‘linear’ progression. Progress is likely to be irregular with many moving into and out of a state of ‘work readiness.’ In order to achieve a continuum of service provision across mental health prevocational or work-preparation, job-training, job commencement and employment maintenance, the responsibilities of State and Commonwealth funded services need to be much more clearly defined (G Waghorn, personal communication, March 2001). Defining responsibilities in this way should be the first step in developing local area networks that are flexible and responsive to the employment needs of people with a psychiatric disability.

2.3.2 Importance of partnerships and networks
There are numerous examples of regionally developed partnership initiatives demonstrating the advantages of a collaborative approach over the current ‘silo’ system. The Hunter Psychiatric Employment Panel (PEP) is one such example. The initial impetus for the development of the Hunter PEP came from the confusing array of services that had to be negotiated in order to access employment under the Disability Reform Program. What was required was a simple pathway to employment linking a range of service providers with the potential to achieve durable employment outcomes. Initially, Hunter PEP included a Commonwealth funded disability employment service (Castle Personnel), the Commonwealth Rehabilitation Service (CRS), the then Department of Social Security (Disability Support Program) and Hunter Mental Health’s Psychiatric Rehabilitation Service. This program efficiently directed individuals to the services that could most adequately meet their needs. If a person had mental health problems that were limiting or reducing their capacity to benefit from pre-vocational or vocational programs, they would be referred to the Psychiatric Rehabilitation Service. If, on the other hand, the person had many of the requisite skills, referral would be to CRS or Castle Personnel, depending on the level of on-the-job support required. Although Centrelink subsequently adopted a coordinating role for Commonwealth instrumentalities and non-government organisations, the linking of state funded mental health services and Commonwealth funded vocational rehabilitation and employment services was provided by a modified Hunter PEP.

In the first two years of the operation of this partnership, 170 consumers were referred to Hunter PEP. Of those referred, 40 were successfully supported in open employment, 70 were referred for work skills development and rehabilitation and 20 were referred to mainstream educational services, a success rate of 76.5%.

Data from the LPDS supports the view that psychiatric rehabilitation programs can increase participation rates in people with psychotic disorders. Figures 1 to 3 show a comparison of participation rates for people with psychotic disorders according to extent of rehabilitation involvement.
2.3.3 Summary

Although an improvement over the service funded model, the case based funding model, by itself, still does not lead to higher rates of participation by people with psychotic disorders. However, the formation of effective intersectoral partnerships or networks that include sound psychiatric rehabilitation programs within the case based funding framework have the potential to increase participation rates significantly.

Recommendation 2

That the Commonwealth and State Governments clearly define their respective responsibilities in order to improve intra- and inter-governmental collaboration.

Recommendation 3

That Commonwealth and State Governments encourage the development of local area networks that are flexible and responsive to the employment requirements of people with a psychiatric disability.
2.4 Early intervention and prevention

The importance of early and appropriate interventions to assist young people with a psychiatric disability to either develop or maintain their capacity for economic and social participation cannot be stressed enough. Whether the onset of the first psychotic episode was acute or insidious, the degree of disturbance is usually profound. As a novel experience, it is usually poorly understood and requires enormous adjustment by the individuals and their families (refer to the case vignette of Thomas – Revisited).

Coinciding with the crucial developmental phase of adolescence or early adulthood, the first psychotic episode interrupts the young person’s ability to achieve a sense of identity, develop as an independent decision-maker, mature as a psychosexual being, establish a set of moral, ethical and spiritual principles and establish realistic social, educational and vocational goals (Manning, 1997). The psychologically compromised young person with psychosis may experience little if any respite from the ambient stresses associated with the onset of the disorder. Without appropriate individually tailored support and interventions, there is a strong likelihood that secondary morbidities may develop, such as post-psychotic depression or substance abuse, and act to entrench disability or the sick role. The active maintenance of social networks, the positive adjustment of the family, and strategies to support educational and vocational expectations are especially important in this period.

For a young person attempting to enter or re-enter the workforce or the education system there are many obstacles to overcome. Loss, low self-esteem and self-confidence, disclosure and stigma, treatment issues, lack of support, and difficulties in identifying and achieving goals have all been identified as major impedients to achieving vocational objectives (Bassett et al. 2001). In addition to learning to cope with a frightening experience, the young person also has to cope with the loss of instrumental skills and the difficulty in acquiring new skills. The cognitive impairments and negative symptoms associated with psychosis vary with the phase of illness and degree of disability (Sparrow, 1985). Depending on the level of impairments and disability, recovery often requires the re-activation of old skills, the teaching of new skills and the development of coping strategies to accommodate the new level of skill (McGorry, 1992). The acquisition of skills should occur in a manner consistent with the recovery needs of the individual and not in an environment marked by relatively high and stressful compliance requirements.

To optimise recovery and prevent or reduce the extent of associated disabilities, young people require access to social welfare support that is consistent with mental health early intervention and prevention strategies. In the absence of a more appropriate supportive social benefit most young people are placed on the activity-tested Newstart Allowance. Unable to maintain the job search requirements and cope with the risk of being breached, many gradually come to accept the more stigmatised but less stressful DSP. For those who reside in the family home or have minimal accommodation costs, the DSP is considered quite generous, but it has the potential to create resignation and dependency as the exploration of employment options becomes a high-risk strategy that has the potential to jeopardise their quality of life. It is unclear why social support systems such as the Job Pathway Program (JPP) or Job Placement, Employment and Training (JPET) have not been used or adapted to assist young people with psychosis.

2.4.1 Benefits and hazards of proposed welfare reforms

The Commonwealth Government’s proposed reforms of the social welfare system aim to provide a safety net for those in genuine need, encourage self-reliance and provide more practical support for people in vulnerable situations (Newman, 2000). Individuals will be streamed into one of three levels of support according to their capacity to benefit and life circumstances (Final Report of the Reference Group on Welfare Reform, 2000). The levels of assistance will include: self-help, low-level brokerage and high-level brokerage. An assessment tool similar to the WATs will be used to
inform the streaming decision and individuals will be encouraged to collaborate with an assessment agency or service broker to develop a participation plan. Each plan will detail the supports/interventions required for the individual to study and/or work to the full extent of their capacity. In addition to job search activities the young person may be required to complete a minimum number of hours of participation in part-time education and training, job search training, work for the dole, and volunteer work.

These reforms of the social welfare system are underpinned by the principles of early intervention and prevention, individualised assistance and intersectoral collaboration. It is unclear, however, how the system will be implemented. The implementation may define a system with a marked focus on compliance, and a limited concern for the life circumstances of the individual and their capacity to benefit. In this instance, the attendant risk is that people with a psychiatric disability may have to endure being breached, with the accompanying loss of benefits. Breaching and the possible eventual assignment to the ‘unable to contribute’ group has the obvious potential to impact adversely on the short- and long-term mental health of the individual. If, on the other hand, the implementation of welfare reform is faithful to its underlying principles, the proposed reforms will have a high degree of complementarity with mental health early intervention and prevention strategies. The system may also provide considerable benefits for those with established or more chronic illnesses, possibly reducing the level of disability in the first five to ten years post diagnosis.

It has become evident that treatments/interventions alone are inadequate to reduce the enormous personal, social and financial burden associated with psychotic disorders. ‘Effective action to promote mental health, prevent the development of mental health problems, and intervene early in mental disorders requires cooperation, commitment and partnerships that reach well beyond mental health services’ (National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000, p1). The need to develop effective early intervention partnerships to reduce disability and handicap cannot be stressed enough and is exemplified by data from the LPDS (Jablensky et al., 1999). A large proportion of people with psychotic disorders included in the study had left school at 16 years of age or earlier. Almost half (48%) had neither completed secondary schooling nor attained any further post-school qualification. Participation in further education also occurred at a low rate, particularly for males, with only 15% of the total sample enrolled in further part-time or full-time education (males 12.6%, females 18.5%).

2.4.2 Summary

Early intervention to assist young people with psychoses to enter into or resume social and economic participation to the greatest extent achievable must occur as soon after the onset of psychosis as possible if longer term outcomes are to be improved and individuals are to reach their full potential. The Commonwealth Government’s proposed welfare reforms appear likely to facilitate the achievement of these objectives, provided that the implementation of the reforms is sensitive to, and can accommodate, the particular needs of people with psychotic disorders.

Recommendation 4

That the Commonwealth Government ensures that the implementation of social welfare reform is consistent with the mental health principles of early intervention and prevention and the recovery needs of people with severe or chronic psychiatric conditions.
Case vignette

Thomas revisited

The case of Thomas, a young man with schizophrenia, was initially presented in the Interim Report of the Reference Group on Welfare Reform (p. 15). As clinicians with long experience treating psychoses, reading this case provoked the reaction: ‘if only things were so simple and had such a positive outcome in so short a time!’ We have therefore rewritten the case of Thomas to illustrate the road usually travelled by young people with psychosis and where interventions might be provided that could alter the course of psychotic illness for the better.

Thomas was a seventeen-year-old in the final year of High School. He had been in frequent contact with his general practitioner (GP) who was treating him for somatic concerns, fatigue and feelings of depression. The GP was aware that during this period Thomas had become socially withdrawn and had refused to participate in a number of school functions.

Referral at this point to a clinical service attuned to the principles of early psychosis prevention and intervention may have led to early detection and treatment of Thomas’s illness with subsequent reduction of morbidity.

The GP did not become overly concerned until six months later when Thomas arrived for an appointment looking dishevelled and speaking in a confused and unusual manner. The GP referred Thomas to the local Community Mental Health Team (CMHT).

Thomas reluctantly agreed to an assessment by the local CMHT. Thomas’s parents gave a history of worsening social withdrawal, irritability and declining academic performance over the past few months. The parents were concerned because Thomas’s maternal grandmother had been admitted to psychiatric hospitals on a number of occasions. They described Thomas as a gentle young man who was slightly prone to clumsiness. He had a circle of friends, but never a girlfriend.

At the initial interview with the staff of the CMHT, Thomas presented as tired and nervous. He told the workers that for several months people on the radio and television had been trying to warn him of an impending danger. Lately he had been hearing a voice telling him to ‘look right’. Thomas also admitted that he regularly smoked marijuana. During the interview Thomas also mentioned that he was extremely concerned about his Year 12 examinations and that he often argued with his father about his academic performance.

The diagnosis of schizophrenia could have been made on the basis of psychotic symptoms of several months’ duration preceded by a longer period of decline in function and non-psychotic symptoms. Ideally, at this point, the CMHT should have undertaken a comprehensive assessment and provided family psychoeducation interventions and weekly specialised counselling sessions over one year. A careful appraisal of Thomas’s ability to complete year 12 of school successfully would probably have resulted in a recommendation to reduce
Case vignette: Thomas revisited

Thomas was experiencing pressure to perform beyond his current capacities and to transfer his studies to part-time through a TAFE college. Attendance at a program for young people with recent onset psychosis to help him learn to cope with his illness and reduce his marijuana use would also have been useful at this stage. A participation support payment could have been linked to Thomas’s involvement in this treatment program.

The Psychiatrist on the CMHT prescribed Thomas a low dose of antipsychotic medication. After two weeks away from school, Thomas recommenced his studies and was doing reasonably well for a time. However, his performance began to deteriorate and his usage of marijuana increased substantially. The friction with his father escalated, as Thomas became more irritable. Thomas also informed his parents that he could not see any point in taking his medication. After a couple of months Thomas left school. He also informed his parents that he was intending to leave home.

Urgent intervention should have occurred at this point since medication adherence is likely to decline or become erratic and a major psychotic relapse, triggered by marijuana use and conflict at home, is likely to occur. A ‘rescue package’ of intensive treatment and family intervention is needed. With abandonment of his studies an evaluation of his education/training requirements and consideration of his vocational interests should occur as soon as the current crisis has settled. At this time the participation support payment should be renegotiated and some incentive included to encourage him to continue living with his family, provided the family conflict can be overcome.

The CMHT had previously referred Thomas and his parents to a mental health education and support group. The decision not to refer Thomas to a specific support program for young people who had recently experienced a psychotic episode was revised. Thomas indicated that he was keen to attend but never did.

Assertive outreach at this point may have been helpful in encouraging Thomas’s attendance, but his failure to turn up was ignored by the group leaders and not communicated to his case manager.

Thomas’s ‘laziness’, drug taking and failure to return to his studies continually angered his father. The level of friction eventually became intolerable for Thomas and he left home.

After not hearing from Thomas for some months, the parents received a call from the local psychiatric hospital where Thomas had been admitted acutely psychotic, dishevelled and malnourished following extensive use of marijuana and also amphetamines. Thomas was requesting to come home. Thomas’s mother convinced her husband to give their son another chance. The father reluctantly agreed but on the condition that Thomas completed his studies, attended the mental health support program for young people and stopped using marijuana.

This is a critical point for Thomas who is in danger of establishing a pattern of medication non-adherence, drug abuse, refractory psychotic symptoms, and major decline in social function and ability to work.

With the assistance of a Counsellor, Thomas commenced a TAFE transition course. Although Thomas applied himself, he struggled to maintain an acceptable standard, complaining of difficulties with concentration, attention and memory. Thomas
continued to use marijuana, although the mental health support group was helping him to gain some insight into the effects of marijuana on his mental health.

*It would have been important at this point to undertake a thorough clinical reappraisal and package a comprehensive treatment, rehabilitation and support program with a renegotiated participation support payment linked to aspects of this program. The possibility of living with a foster family devoid of conflict focused on Thomas might have been facilitated by means of a supplementary payment, or part of his allowance, being paid to a suitable foster family as long as he continued in this program. A mobility allowance to enable him to attend a vocational rehabilitation program may have been crucial in ensuring attendance.*

By this stage, two years since his difficulties began during his final year at High School, Thomas’s social network had essentially disintegrated. His friends were struggling to cope with the strangeness Thomas had developed. In an attempt to demonstrate the contrary, Thomas often over compensated, drinking and smoking too much. On one occasion he was arrested for driving under the influence of alcohol.

*This presented another missed opportunity to engage Thomas more successfully in a treatment and rehabilitation program owing to poor liaison between the police, magistrate’s court, mental health services and income support systems.*

Thomas often requested money from his parents without disclosing that he intended to procure the services of a prostitute. Although the mental health education and support program was assisting Thomas’s parents to develop a better understanding of their son’s psychotic disorder, his father was still struggling with this issue. After a number of altercations, the level of conflict between Thomas and his father escalated to the point of physical violence. After one such incident, Thomas isolated himself in his room for a number of days, talking to himself and not eating or washing, and the CMHT were called to provide assistance which resulted in a further period of hospitalisation.

*Another attempt to renegotiate the same package referred to above ought to have taken place at this point.*

Thomas left the TAFE transition course, although he still attended the young peoples’ support program. Under pressure from his father, Thomas accepted a full-time clerical position in a business owned by a family friend.

*Ad hoc or opportunistic attempts to re-enter employment without proper assessment, reasonable matching between the patient’s abilities and the demands of the job, and adequate support are likely to fail, especially if the job has been arranged through family connections which are often accompanied by emotional investment that adds another dimension of psychological burden for the patient.*

However, the stresses of full-time work gradually exceeded Thomas’s ability to cope. Thomas began taking time off and when at work, he often left his work position for long periods. After a number of warnings, Thomas was sacked from the company and attempted to find a position that was more consistent with his abilities.

*This would have been very damaging to Thomas’s self-esteem and may have triggered a depressive episode leading to suicide.*
Through the young peoples’ program, Thomas was referred to psychiatric prevocational training program.

Through a structured skills building program, the psychiatric prevocational program assisted Thomas to develop the skills necessary to obtain employment. The psychiatric prevocational program was designed to accommodate Thomas’ cognitive, social and motivational limitations. After graduating from the program, Thomas was referred to a specialist supported employment program where he obtained a part-time position in the hospitality industry.

*This intervention should have occurred much earlier in the course of this young man’s illness. Much time and effort has been wasted owing to inadequate assessment, treatment and rehabilitation, and ineffective or absent linkages with various sources of support that have had insufficient scope and flexibility to deal with the complexities that occur in the early course of psychotic disorders.*

After two years in supported employment – and five years since the onset of his illness with many missed opportunities for more assertive early intervention and rehabilitation – Thomas secured a part-time position in open employment. He was able to achieve this appointment with the assistance of a specialist employment service that provided time-limited on the job support. Thomas has found the new position to be quite demanding but is determined to persevere as he wants to move into his own accommodation in the near future. He continues to use marijuana and alcohol.

*This young man is clearly still at high risk of relapse and deterioration, and requires flexible ongoing support and treatment until his condition has more firmly stabilised.*
2.5 Psychiatric rehabilitation

2.5.1 Mental health service barriers to employment

Although a sizeable group of people with a psychotic illness will attain a good level of social and occupational functioning and relative stabilisation of their disorder, many will experience little if any recovery or respite from their symptoms. Chronic symptoms or multiple episodes with partial recovery, can be accompanied by minor or major functional deterioration. Impairments in cognitive, affective and social functioning are common and markedly reduce or even preclude access to a range of mainstream community services. Specialist community based services are few, particularly in rural areas, as a consequence of the failure to effectively provide communities with the means to meet the broad-based needs of people with severe psychiatric disabilities after the downsizing and closure of long-stay hospitals.

Although community mental health teams were established with the expressed intent of providing broad psychosocial support and have made a large contribution to the management of severe mental illness, several factors have contributed to community treatment becoming substantially confined to the domain of medication maintenance. The responsibility for meeting the needs of people with severe mental illness in regard to accommodation, social and recreational activities, and employment has largely fallen to the disabled person and non-government organisations, with little or no contribution from mental health services in these areas. The findings of the LPDS reflect the poor employment and social outcomes that flow from this. As shown in Table 2, less than 20% of people with psychotic disorders were employed either full or part-time. In addition, almost one-third lived alone and more than one-half were described as socially withdrawn (Jablensky et al., 1999).

Table 2 Employment status and classifications in the LPDS

<table>
<thead>
<tr>
<th>Current employment status</th>
<th>Males</th>
<th>Females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td></td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>No job at present</td>
<td>76.9</td>
<td>64.7</td>
<td>72.0</td>
</tr>
<tr>
<td>Full-time job</td>
<td>5.8</td>
<td>6.1</td>
<td>5.9</td>
</tr>
<tr>
<td>Part-time job</td>
<td>12.5</td>
<td>12.9</td>
<td>12.7</td>
</tr>
<tr>
<td>Housework</td>
<td>0</td>
<td>8.1</td>
<td>3.3</td>
</tr>
<tr>
<td>Studying</td>
<td>1.5</td>
<td>4.1</td>
<td>2.5</td>
</tr>
<tr>
<td>Retired</td>
<td>2.4</td>
<td>3.3</td>
<td>2.8</td>
</tr>
<tr>
<td>Not Stated</td>
<td>0.9</td>
<td>0.8</td>
<td>0.8</td>
</tr>
</tbody>
</table>

An analysis of the LPDS data was conducted comparing psychotic persons involved in paid employment or other forms of meaningful participation with those not participating. This analysis revealed that those who were not involved in some form of participation were more likely to be male, have lower levels of education and higher levels of disability, and were more likely to have comorbid substance abuse. These findings are shown in Table 3.
Table 3  Participation status and demographic and lifestyle factors in the LPDS

<table>
<thead>
<tr>
<th>Participation statusa</th>
<th>Not participatingb</th>
<th>Participatingc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male %</td>
<td>Female %</td>
</tr>
<tr>
<td></td>
<td>79.5</td>
<td>67.5</td>
</tr>
<tr>
<td>Mean age at interview (Yr)</td>
<td>39.16</td>
<td>37.00</td>
</tr>
<tr>
<td>Mean age at leaving school (Yr)</td>
<td>15.97</td>
<td>16.73</td>
</tr>
<tr>
<td>Mean disability (SOFAS) scored</td>
<td>49.81</td>
<td>65.28</td>
</tr>
<tr>
<td>Lifetime diagnosis of substance abuse or dependence (%)</td>
<td>Alcohol</td>
<td>33.3</td>
</tr>
<tr>
<td></td>
<td>Cannabis</td>
<td>28.5</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>14.7</td>
</tr>
<tr>
<td>Amphetamine use in previous year (%)e</td>
<td>13.0</td>
<td>8.4</td>
</tr>
</tbody>
</table>

* Those who were retired or in long-term hospitalisation were not included in this analysis.
† Those referred to as not participating were those who indicated that they were currently unemployed.
‡ Those referred to as participating were involved in full time or part time employment, housework, or study.
§ Disability was measured using the Social and Occupational Functioning Assessment Scale (SOFAS), with scores ranging from 0 to 100 (high scores indicating low disability and vice versa).
¶ Lifetime amphetamine abuse/dependence is recorded, together with certain other substances, under the category ‘Other’ in the line above. Amphetamine use as separately recorded here identifies the proportion of subjects who reported using amphetamines in the previous 12 months. This separate analysis was conducted because amphetamine use is reported to exacerbate psychotic disorders.

Early reports by the National Mental Health Strategy (Whiteford et al., 1993) proposed that barriers to the better use of mainstream services often came from within mental health services themselves. The report suggested that staff needed to give up their ‘ownership’ or ‘paternalistic’ attitudes towards their clients. ‘They must accept the boundaries of mental health responsibilities and link patients into the full range of disability and social support services to which they are entitled’ (p. 53). From a Commonwealth Rehabilitation Service (CRS) perspective, Nicholson (1994) stated that mental health workers did not believe that open employment was a realistic option for more than a few of their highest functioning clients. Many of the clients with a psychiatric disability reported that they were rarely asked by their mental health worker about their vocational interests (Nicholson, 1994). Medical staff were considered to be particularly resistant to employment as a rehabilitation option for the mentally ill owing to their perceptions of patient incapacity, medication effects and concerns about relapse (Graffam & Naccarella, 1994).

In a study of 719 people diagnosed with schizophrenia, Lehman and Steinwachs (1998) found that only 22% of outpatients were receiving vocational rehabilitation services or had such services included in their treatment plans. Mental health services accounted for only 35% of all referrals to the specialist CRS program, and only 26% of those commencing the program. The difficulty in engagement was attributed to an inadequate preparation of clients through mental health supported pre-vocational programs. In the LPDS only 19.1% of participants had been involved in rehabilitation programs in the previous year and only 7% had been involved in such programs for 6 months or more.
2.5.2 Access to psychiatric rehabilitation and its benefits

Access to mental health rehabilitation programs is considered critical in the development of intersectoral partnerships to achieve employment outcomes (Nicholson, 1994). The apprehension that attends the risk of moving beyond the disability and recovering or developing an instrumental role is profound. With the onset of psychosis typically occurring at the time of entry or preparation for entry into the workforce, young people with psychotic disorders have little understanding of the issues involved in employment (eg, punctuality, regard for authority, work roles, etc.) and skill levels are relatively underdeveloped. Owing to the impairments associated with psychosis (eg, concentration, memory, etc.) special interventions and training techniques are often needed to habilitate or rehabilitate occupational and social skills. For those who choose to move into employment, avoidance of failure is critical and requires a gradual development of skills in a supportive context that strongly encourages the development of self-esteem along with a sense of mastery.

An example of an area in which mental health rehabilitation services can contribute is that of social skills training. In a two-year follow-up study, Johnstone et al. (1990) found that people with schizophrenia who had poorer vocational outcomes also had poorer overall social skills. Employability has been associated with higher levels of communication skills and social adjustment (Charisiou et al., 1989), and unsatisfactory job terminations have also been linked with a failure to manage interpersonal problems (Becker et al., 1998). Although it has been argued that skills acquisition can only occur in vivo, a recent study found that work-related social skills training can generalise and that these skills are transferable provided there is a very clear focus and a desirable end product (Tsang and Pearson, 2001).

2.5.3 Importance of early rehabilitation

The need for psychiatric rehabilitation is often overlooked in the early stages of psychosis. Clinicians often do not refer patients for rehabilitation until quite late in the course of the illness. Unfortunately, as the delay increases so too does the limitation on what can be accomplished. As a consequence, rehabilitation services are often placed in the situation of providing disability support instead of clinical rehabilitation. Since so much of the later course of psychosis is determined by what takes place in the first few years after onset, it is imperative that a large investment is made as early as possible in treatment, and in the delivery of both social and vocational rehabilitation. This will increase the likelihood of a better outcome. Hence, early identification of rehabilitation requirements and early referral for appropriate intervention of this kind is a critically important strategy to pursue.

By acquiring employment skills in a well-designed rehabilitation program, people with psychosis can be assisted in regaining lost self-confidence, self-esteem and sense of worth. Being well prepared for work means that the individual is less likely to be stressed and the employer is more likely to be satisfied. This in turn means that the employer may subsequently be more receptive to employing people with a psychiatric disability. A systematic approach to the acquisition of personal and vocational skills also has the potential to increase the range of employment opportunities and to increase retention rates (Crowther et al., 2001).

2.5.4 Summary

The failure of mental health services to fully appreciate the need for, and potential benefits of, early psychiatric rehabilitation may be an important contributing factor to low rates of involvement in psychiatric rehabilitation programs by people with psychotic disorders. There is a need to increase awareness among mental health services of the importance of early psychiatric rehabilitation in the psychoses and to increase the rates of participation in psychiatric rehabilitation programs.
Recommendation 5

That State Governments ensure mental health services adopt a consistent, state wide approach to service delivery that complements Commonwealth employment initiatives. Mental health services should accommodate the employment-related needs of consumers, including early rehabilitation and support, as well as rendering expert assistance to specialist employment services as integral components of service delivery.

2.6 Vocational rehabilitation

In Australia, the Commonwealth Rehabilitation Service (CRS) has traditionally provided vocational rehabilitation services. Having neither the resources nor the expertise to provide intensive support for people with moderate or severe psychiatric disabilities (Graffam & Naccarella, 1994), CRS has generally focused on the provision of services for people with low levels of psychiatric disability. With open and supported DFaCS funded services and business units predominantly catering for people with intellectual disabilities, there have been relatively few opportunities for people with psychiatric disabilities to make the transition into employment. In an attempt to bridge this gap, a number of small scale state funded transitional employment programs have been developed. However, the Report of the National Inquiry into the Human Rights of People with Mental Illness (1993) found that governments had hitherto neglected vocational rehabilitation for people with mental illness. The Report stated that the needs of this group were varied and proposed that ‘a range of graduated, transitional, vocational and rehabilitation services need to be developed to provide greater access to employment opportunities and more meaningful use of non-working time’ (p.922).

2.6.1 Supported employment programs

Supported employment has been shown to be one of the most effective strategies for obtaining and retaining employment for people with psychiatric disabilities who suffer diverse symptoms and impairments (Mueser et al., 1997b, Crowther et al., 2001). In a review of seven controlled investigations, (Mueser et al. 1997b) concluded that the results were remarkably consistent in demonstrating the effectiveness of supported employment in achieving high rates of competitive employment. In the controlled studies, the unweighted average for obtaining competitive employment was 58% for participants in supported employment and 21% for controls. These studies also showed that supported employment programs had comparable advantages in terms of hours worked and wages earned. The pre/post studies reviewed also demonstrated a similar success rate (Mueser et al., 1997b). The review highlighted a number of issues critical to the success of people with severe mental illness in the employment market.

Two points are of particular relevance in this context. First, direct assistance is required for people with a psychiatric disability to find and keep employment. Indirect methods such as counselling and job interview training, by themselves, are less effective (Bond et al., 1995). Second, the integration of vocational and clinical services at the level of service delivery are more effective than when separately provided, a point that has also found support in a more recent study by Cook and Razzano (2000). Although there appear to be considerable advantages in providing supported employment opportunities, access remains a critical issue with very few severely mentally ill people able to take advantage of such services in the USA (Mueser et al., 1997b) or Australia.

2.6.2 Limited access to supported employment

As outlined previously, access to supported employment has largely been limited to people with an intellectual disability. According to the 1999 Disability Services Census, 11,621 people with an intellectual disability were accessing supported employment services, compared to 1,603 people with a primary diagnosis of psychiatric illness. In services providing only supported employment,
people with an intellectual disability and those with a psychiatric disability occupied 76.2% and 6.8% of all positions, respectively. Between 1997 and 1999 the number of positions occupied by people with a psychiatric disability improved by only 1.2%. Although funding was increased for specialist supported employment programs in the past few years, demand still far outstrips the number of available positions. For example, Western Australia has only one specialist employment service for people with a psychiatric disability. The waiting list for this service is reported to be in excess of 160 people (Welfare Reform and Psychiatric Disability – Striking a better balance, 1999). Within the sector there needs to be much greater development and support for specialist supported employment programs that incorporate innovative approaches.

In Newcastle, a specialist supported employment service, Hunter Joblink Inc, operates in partnership with mental health services in providing employment to people with a psychiatric disability. This program has successfully utilised the new apprenticeship/traineeship scheme to provide training and employment opportunities for people with a psychiatric disability.

2.6.3 Future risks and opportunities

If a new capitation funding model is introduced for people with psychiatric disabilities, the retention and further development of entrepreneurial specialist employment services will be imperative. There is a strong possibility that under the case-based funding model, specialist employment providers will be required to adopt a generic approach. Although the philosophy of this approach is commendable, the practice has the potential to profoundly affect outcomes, particularly for people with psychiatric disabilities. With the abolition of block funding, supported employment services may develop a preference for referrals that underwrite the service’s viability. Factors such as the type of service or business operated and the expertise available will also affect referral selection. The reported lack of confidence in the new profiling tools may also encourage a more conservative approach to referrals.

In order to maintain outcomes, service providers may therefore be required to develop or purchase expertise that can meet a range of disability requirements. For employees with a psychiatric disability, the capacity of mental health services to provide clinical support will be affected by the reduced efficiencies associated with working across multiple sites, with differing levels of expertise. A range of supports and other subsidies provided by state-based mental health services might be curtailed as the generic focus is developed. At a more fundamental level, whilst some disability groups are compatible, the prejudices that prevail in our communities about mental illness and developmental disabilities are also evident in the disability sector.

The introduction of the case-based funding approach may, in itself, lead to the development of a range of new opportunities for people with psychiatric disabilities. With the limited availability of positions in specialist supported employment services, new opportunities will be substantially limited to the open employment market. For some disability groups and for some levels of disability, this would be a desirable and welcomed outcome. For those people with higher levels of disability, the transition into open employment may come too quickly and require an adjustment that the individual is unable to accommodate, even with higher levels of support and prior involvement in mental health rehabilitation programs. For many people with a psychiatric disability supported employment in specialist services may be their only employment outcome, whilst for others it may be an essential step to open employment and a better quality of life.
2.6.4 Summary

Supported employment programs have demonstrated effectiveness in assisting people with severe psychiatric disorders to enter the workforce. However, people with psychotic disorders are not gaining sufficient access to these programs at a level commensurate with the prevalence of these disorders in the community. The main risk of case based funding, as currently operating in this context, is that access to supported employment programs by people with psychiatric disabilities may be further compromised with adverse flow-on effects in terms of longer term outcomes.

Recommendation 6

That the Commonwealth Government develops supported employment opportunities for people with a psychiatric disability who are unable to accommodate a rapid transition into open employment.

Recommendation 7

That the Commonwealth Government develops innovative employment models that benefit from but are not limited by existing models of service provision.

2.7 Vocational education and training

2.7.1 Access issues

As a result of a raft of legislative initiatives introduced by both Commonwealth and State Governments over the past 15 years, more disabled people than ever before are accessing vocational education and training. The overall participation rate remains relatively poor however, with the likelihood that the distribution across disability groups also does not mirror prevalence figures. Data published by the Australian Bureau of Statistics indicated that 16.7% of working age Australians have a disability. Of the total population engaged in vocational education and training, only 3.6% reported having a disability. Of this group, almost 20% had left school before the age of 15 years. The report of the Australian National Training Authority (ANTA, 2000) indicated that although 1 in 10 Australians participate in vocational education and training, only 1 in 40 people with a disability participate in these programs. In regard to New Apprenticeships, only 1 in 50 people with a disability undertake an apprenticeship. Students without a disability take up New Apprenticeships at the rate of 1 in 6. Of those who do enrol in vocational education and training programs 13% withdraw. The pass rate for those who choose to continue is lower than that for people without a disability (ANTA, 2000). The report also highlighted that people with a disability more frequently enrol in basic education and basic employment skills programs, and are over represented in lower labour market demand and declining industry areas.

In formulating the national strategy on vocational education and training, one of ANTA’s key recommendations concerned the pathways to services. Recent changes to the vocational education and training sector to improve the range and responsiveness of options have resulted in a complex system that is not widely understood. If the system is not well understood, obviously access will be affected, particularly for people with a disability. In addition to clarifying the system, ANTA recommended that links should be developed between schools, pre-vocational services and disability employment assistance to improve access, support and placement.

Interagency links between mental health and vocational education and training organisations such as TAFE, are commonplace. If regions in NSW are indicative, the nature of the relationship has failed to fully mature as a partnership because financial imperatives have directed the development and provision of programs. For example, TAFE promotes courses that have student to staff ratios of
15:1. With preferred ratios for people with a disability around 8:1, outreach programs and programs for people with special needs have become increasingly difficult to access. It is highly probable that disabled people will be streamed into generalist courses. This may be appropriate for some, but for those with more profound disabilities, which may include associated learning and memory difficulties (as in psychotic disorders), participation in generalist courses will eventually act as a disincentive and in some cases will preclude involvement.

2.7.2 Summary

Participation in vocational training and education by people with psychiatric disabilities is low and needs to be enhanced by systemic adjustments that lead to greater accessibility for the mentally ill. Effective collaboration between vocational training and education organisations and mental health services should help to increase the responsiveness of such organisations to people with mental illness and enhance the level of support they receive during their training.

Recommendation 8

That the Commonwealth Government implements strategies to markedly improve and ensure access to vocational education and training programs for people with psychiatric disabilities. State Governments need to ensure the availability of mental health service support for staff conducting such programs.

Recommendation 9

That State Governments review the financial imperatives currently impacting on the availability of TAFE special programs in order to improve and ensure access for a range of disability groups including those with severe mental illness.

2.8 Supported education

Supported education programs for people with a psychiatric disability were developed by the Center for Psychiatric Rehabilitation at Boston University in 1984. The aim of the programs was to provide access to university or higher learning opportunities through a normal, non-stigmatising environment. Although there is no particular model linking supported education endeavours, such programs usually include academic and functional assessment, assistance with career choices, skills teaching (study skills, stress and time management, etc) and the utilisation of equipment (computers, etc). Assistance is usually provided in facilitating admission and course registration and access to campus based services such as financial and recreational resources. Studies of supported education programs have shown that although attendance tended to wane over time and was associated with a high withdrawal rate, those who persevered achieved pass rates consistent with the general student body (Dougherty et al., 1992). In a review of supported education programs, Baronet and Gerber (1998) concluded that these programs were associated with positive effects on quality of life, educational and occupational status.

Recommendation 10

That Commonwealth and State Governments increase the availability of disability support staff in tertiary learning facilities who have expertise in mental health, and ensure that access is not limited to those on the DSP.
2.9 Summary

There are multiple barriers to the employment of people with psychotic disorders. These include:

- job seeker assessment methods that are not well suited to important characteristics of mental illness,
- a lack of suitable positions in specialist employment services,
- insufficient development of effective intersectoral partnerships,
- failure of mental health services to actively pursue early rehabilitation strategies and provide appropriate expert assistance to specialist employment services,
- poor access to sound evidence based interventions such as supported employment programs, and
- insufficient availability of suitable vocational training and education programs.
3. Costs of participation

3.1 Child care

As outlined in the Interim Report of the Reference group on Welfare Reform (March 2000), a number of submissions highlighted concerns about child-care for low income families and sole parents who do not have the support of other family members. The LPDS revealed that 33.06% of people with psychotic disorders have children and 7.96% are caring for their children at home. For parents with a mental illness, the difficulties associated with accessing information and support regarding child-care needs often limits participation in education, training and vocational rehabilitation.

Recommendation 11
That the Commonwealth Government encourages parents with a mental illness to participate in psychiatric and vocational rehabilitation programs through a social welfare system that ensures adequate child-care for mentally ill parents.

3.2 Mobility Allowance

Currently the mobility allowance is only available for disabled people attending vocationally oriented programs for at least 8 hours per week. Consistent with the thrust of the Commonwealth Government’s reform program, consideration should be given to extending the availability of the mobility allowance to include people who are attending rehabilitation programs or other support services that may eventually assist the person in returning to work or developing their role in socially valuable projects. The existing Mobility Allowance is commendable for the incentive it provides for a gradual return to work. However, accessibility is limited by shortcomings in the assessment process that tend to disadvantage people with a mental illness.

Recommendation 12
That the Commonwealth Government reviews the assessment and monitoring procedures for the Mobility Allowance to remove any elements that may disadvantage people with a mental illness.

3.3 Accommodation

The type of accommodation occupied by a substantial proportion of people with psychosis does not provide a sense of ‘permanence’ that would facilitate stable employment. Access to public housing that provides stability and quality of life is critical to the maintenance of employment. In the month prior to interview, 45% of the LPDS sample had been accommodated in an institution, hostel, group home, supported housing, crisis shelter, or were homeless. While 31% had resided in a rented home (public or private), only 15% of the sample had resided in their own home and 15% lived in a family home. (Because some individuals used more than one type of accommodation, the sum of the percentages given here exceeds 100%.) Access to public housing is restricted by insufficient stock and extended waiting lists. Incentive structures within the public housing sector should be consistent with the objective of encouraging the mentally ill to participate in valued social and vocational activities.
It is important to note that a large number of people with a psychiatric disability, who are capable of greater social and occupational participation, are restricted from doing so by the lack of available quality supported accommodation. When supported accommodation is available it is usually very expensive. The level of fees charged in many boarding houses and hostels often precludes residents with mental illness from accessing specialist employment services or community projects.

**Recommendation 13**

That Commonwealth and State Governments develop new strategies to improve access to safe, secure and affordable accommodation for people with psychiatric disabilities. Access to supported accommodation for people with moderate to severe mental disorders remains a critical issue.

### 3.4 Family living

#### 3.4.1 The value of family support

Stable secure accommodation together with the type of companionship, support and buffer against stress that families often provide is associated with better outcomes for people with psychotic disorders. One of the explanations for the better outcomes seen in people with psychotic disorders who live in developing countries is that, by continuing to live with their families, such persons are able to participate usefully in the family-based enterprises and subsistence farming that prevail in those cultures. However, not all western industrialised countries have a tradition in which people with psychoses live apart from their families. A study conducted in Bologna, Italy, for example, found that 70% of people with psychoses were living with their families, and that these people had a better quality of life than a comparable sample in the USA where only 17% lived with their families (Priebe et al., 1998). People living with their families do not generally suffer from repeated changes in accommodation and the stress this causes, have more disposable income since they pay less in rent, are better nourished, and require less support and supervision from mental health services which are thereby freed to provide more occupational rehabilitation services. The value of maintaining positive family involvement has been reflected in an Australian study of people employed in specialist employment services. Graffam and Naccarella (1994) found that 63.1% of respondents experienced emotional support and encouragement from their families and 13.1% received assistance with child-rearing, transport and job searching.

Not all natural families are able or willing to provide the ongoing level of support needed for young people struggling to cope in the early years of severe mental illness. Unfortunately, some families tend to generate more stress than they buffer, leaving the disabled person with little or no family support. In some cases social isolation is further exacerbated by the social impairments associated with the illness. A lack of close family or personal relationships was reported by a large minority of the LPDS participants: 35% did not have regular face to face contact with a close relative, and 39% said they had no intimate friend with whom to share thoughts or feelings. Almost one-third (31%) were living alone and only 9% had a carer at home to look after them. Yet 30% of the sample were seriously impaired in their ability to take care of themselves (including personal hygiene, care for one’s own appearance and efforts to keep physically fit).

#### 3.4.2 Strengthening family support

Encouraging young people with moderate to severe disabilities to continue living in a supportive family environment is likely to improve social and occupational functioning and increase the probability of taking up productive social roles and leading a more fulfilling life. Family interventions provided early in the course of the illness reduce the stress, guilt and burden associated with the
disorder, as well as contribute to improved short-term clinical outcomes for the psychotic family member. There is a need to develop a robust social support structure capable of assisting the disabled person regardless of whether they remain in the family home or live independently.

Financial incentives should also be available to support a carer within the family. In principle, the Carer’s Pension is available for family members providing care. In practice, however, the Carer’s Pension is very difficult to obtain. Again, it is not clear whether the assessment protocol disadvantages people with a mental illness by failing to address the support needs associated with severe episodic conditions.

An alternative approach may be to introduce a special family allowance scheme to support young people in the first few years after onset of a psychotic disorder. The allowance could be payable to the natural family or foster family with whom the mentally ill person resides. The allowance could be paid for a defined period of, say, no longer than five years, and on the condition that the mentally ill person is engaged in an approved educational or occupational rehabilitation program, or is employed full- or part-time. The short- to medium-term costs of this additional allowance should be offset by a longer-term reduction in DSP payments brought about by the achievement of successful entry to the workforce. Savings would also be expected in health services such as by reduction in hospital admissions and lower medical costs. If, after the five-year period has passed, the person has not successfully entered the workforce, then such a person may be permanently disabled. In this case, a natural or foster family member may or may not be eligible for a Carer’s Pension under the existing arrangements in lieu of the special family allowance.

3.4.3 Summary

Strong family support can buffer stress, help to improve outcomes for people with psychiatric disorders, and act as a valuable resource in facilitating higher levels of community participation by mentally ill family members. Improved access to the Carer’s Pension would be of benefit to many individuals with severe mental illness. A special family allowance, linked to involvement in programs for increasing participation by psychiatrically disabled people in the early stages of their illness while living with their natural or foster families, would be likely to reduce impairments and enhance functioning in the longer term.

Recommendation 14

That State Governments ensure that Mental Health Services implement a range of early intervention strategies to enhance the coping abilities of families providing support, care and assistance for young people recovering from psychosis. Family intervention strategies should also be developed for those families caring for individuals with mental disorders of longer duration.

Recommendation 15

That the Commonwealth Government improve access to the Carer’s Pension for parents assuming responsibility for the care of their son or daughter disabled by psychotic illness.

Recommendation 16

That the Commonwealth Government explores the feasibility of a special family allowance and/or other incentives with the aim of helping young people in the early years after onset of a psychotic illness to remain living in a suitable family environment while engaged in education, rehabilitation or employment.
3.5 Job design and work environment

Sections 5(2) and 15(4) of the Disability Discrimination Act 1992 indicate that if an employee is able to perform the inherent requirements of a position with an adjustment or accommodation, then the employer is obliged to provide that adjustment or accommodation unless doing so would cause unjustifiable hardship. The adjustment must be reasonable and each situation requires an individual assessment (Bourke, 1996).

The adjustments may simply require an alteration to the physical environment or the adoption of flexible working conditions. For a person with paranoid tendencies, the orientation of the disabled person’s workstation may be an important concern. Facing fellow workers rather than having colleagues working behind them may reduce stress. Having control over the number of hours employed can also have a positive effect on symptoms (Bell and Lysaker, 1996) and job maintenance (Becker et al., 1998). In a study of 30 individuals who held 47 jobs, Fabian et al., (1993) found that the average number of accommodations required per job was 5.1 with the most frequent being the orientation and training of the supervisor, on-site job coaching and modifications to work schedules.

**Recommendation 17**
That State Governments ensure mental health rehabilitation services consult with and advise employers regarding appropriate adjustments to work environments and employment conditions so that employers may more readily conform with the Disability Discrimination Act and improve the likelihood of successful employment by people with psychiatric disabilities.

3.6 Negative attitudes of the community and employers

Negative attitudes towards the employment of people with mental illness are not new. A 1973 study of employer reactions to people with a psychiatric disability found that a history of mental illness was associated with fewer job offers, less friendly behaviour, and a lower estimated probability of finding a job (Farina & Felner, 1973). Bordieri and Drehmer (1986) reported that employers who were hesitant to hire people with psychiatric disabilities tended to perceive the disability as having an internal causative factor over which the individual had considerable control. In a survey of people employed in psychiatric employment services, Graffam and Naccarella (1994) found that more than one-third reported experiences in which people with a psychiatric disability were considered by employers to be violent and stupid. In some cases participants indicated that employers felt that their reputation would be sullied if they employed someone with a psychiatric disorder. In other cases, disabled people were advised not to disclose because the employer would be likely to sack them. A more recent study investigating the attitudes towards mental illness of 917 middle and senior managers from Sydney and Melbourne concluded that approximately one third of managers believe mental illness is a ‘myth’ (Spillane, 1999).

In contrast, Graffam and Naccarella (1994) found that more than two-thirds of mentally ill participants in their study had found employers to be understanding, supportive and knowledgeable about mental illness. Although legislation such as the *Disability Discrimination Act 1992* and assertive campaigns to reduce the stigma associated with mental illness may have had an impact, negative attitudes are still prevalent among employers. As these attitudes appear to be deeply ingrained within the individual and the culture, new initiatives are required to correct the misinformation and to develop a realistic understanding of the vocational capacity of people with a mental illness. The reluctance of employers to hire individuals with mental illness appears to stem from a lack of understanding. By developing programs that specifically take employers’ needs and perspectives into account, both industry and unemployed individuals are likely to benefit.
Recommendation 18

That the Commonwealth Government continues to develop and implement strategies to reduce the stigma and discrimination associated with mental illness. Consideration should also be given to the development of special education programs to assist in the creation of more positive work environments for people with psychiatric disabilities.

3.7 Financial incentives

In not penalising those people on the DSP who attempt to enter or re-enter the workforce on a full-time basis, the current system is very good. For example, if a person fails at work, he/she can almost immediately return to the DSP. However, for people attempting to re-enter the workforce in a more gradual fashion, the system is less encouraging. For example, people on the DSP are currently able to earn $50 per week without affecting their pension ($183/wk). Over and above this, the more they earn, the more their pension is reduced – almost dollar for dollar. There is scope here for flexibility to provide a greater incentive for people with psychosis to enter the workforce successfully. Again, the additional short- to medium-term costs of this initiative should be offset by a longer-term reduction in support payments brought about by the achievement of successful entry to the workforce by the recipients of such benefits.

Recommendation 19

That the Commonwealth Government introduce into the operations of the Disability Support Pension, or the Participation Support Payment, incentives to support job seekers who are unable to make a rapid transition into employment. In particular, there should be an upward readjustment of the level of earnings at which support payments are reduced.

3.8 Government services

Use of and satisfaction with government services varied considerably among participants in the LPDS. Satisfaction with social security services was high, but satisfaction with employment services was low. Only one in four used government employment services despite high levels of unemployment; a similar proportion used government housing services. The percentages reporting that their needs were met by the service were particularly low for those using employment services (57%) though higher for those using housing services (71%). On the other hand, 87% of the two-thirds who used social security services reported that the service met their needs.

Recommendation 20

That the Commonwealth Government develops best practice guidelines for the dissemination of information to people with psychiatric disabilities and establishes an independent complaints/dispute mechanism that is valued by consumer groups.
3.9 Summary

Maximising the employment potential of people with psychotic disorders will entail a substantial initial investment with the expectation that short-term outlays are likely to be more than compensated by longer term savings in health and welfare expenditure, as well as improved quality of life for individuals and families. Components of this initial investment, in addition to the costs of rehabilitation programs, include:

• adequate child-care provision for mentally ill parents,
• greater flexibility in the administration of the Mobility Allowance,
• better availability of suitable – including supported – accommodation,
• strengthening family support through improved access to the Carer’s Pension and other forms of assistance to families,
• ensuring optimal work environments and employment conditions for psychotic individuals in conformity with the Disability Discrimination Act,
• working to overcome negative attitudes among some employers, and
• introducing greater flexibility in stepwise reductions in the DSP as earnings increase in order to achieve a greater incentive to enter the workforce.
4. **Conclusion**

In a society where emphasis is placed on employment as a means of social inclusion, it is imperative that people with psychiatric disabilities are given an opportunity to participate in the labour market. Although disorders such as the psychoses are heterogeneous, having various episodic and disability profiles, the diagnosis is not an exclusion criterion for workforce participation. With a network of psychiatric rehabilitation, prevocational, vocational rehabilitation and employment services, transition from the sick or disabled role to a contributing member of our society becomes a possibility. Prerequisites in achieving this goal are a clarification of the respective State and Commonwealth responsibilities and a social welfare system that operates in a manner consistent with the philosophies and practices of early intervention and prevention. The social welfare system will also require the flexibility to encourage and support people with chronic conditions who have hitherto been considered unable to contribute. Such a system would be a sound investment for the entire Australian community.
Summary of recommendations

Section

2.2 Current system: the Service Funded Model

Recommendation 1
That the Commonwealth Government consults with disability groups in developing more sophisticated profiling and streaming tools that will ensure fair and equitable access to services that are commensurate with individual need. The assessment protocols need to demonstrate sensitivity to the features that characterise severe and disabling episodic conditions.

2.3 Case Based Funding Model

Recommendation 2
That the Commonwealth and State Governments clearly define respective responsibilities in order to improve intra- and inter-governmental collaboration.

Recommendation 3
That the Commonwealth Government encourages the development of local area networks that are flexible and responsive to the employment requirements of people with a psychiatric disability.

2.4 Early intervention and prevention

Recommendation 4
That the Commonwealth Government ensures that the implementation of social welfare reform is consistent with the mental health principles of early intervention and prevention and the recovery needs of people with severe or chronic psychiatric conditions.

2.5 Psychiatric rehabilitation

Recommendation 5
That State Governments ensure mental health services adopt a consistent, statewide approach to service delivery that complements Commonwealth employment initiatives. Mental health services should accommodate the employment-related needs of consumers, including early rehabilitation and support, as well as rendering expert assistance to specialist employment services as integral components of service delivery.

2.6 Vocational rehabilitation

Recommendation 6
That the Commonwealth Government develops supported employment opportunities for people with a psychiatric disability who are unable to accommodate a rapid transition into open employment.
**Recommendation 7**
That the Commonwealth Government develops innovative employment models that benefit from but are not limited by existing models of service provision.

2.7 Vocational education and training

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That the Commonwealth Government implements strategies to markedly improve and ensure access to vocational education and training programs for people with psychiatric disabilities. State Governments need to ensure the availability of mental health service support for staff conducting such programs.

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Recommendation 17
That State Governments ensure mental health rehabilitation services consult with and advise employers regarding appropriate adjustments to work environments and employment conditions so that employers may more readily conform with the Disability Discrimination Act and improve the likelihood of successful employment by people with psychiatric disabilities.

3.6 Negative attitudes of the community and employers

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### Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANTA</td>
<td>Australian National Training Authority</td>
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<tr>
<td>CRS</td>
<td>Commonwealth Rehabilitation Service – Leading provider of vocational rehabilitation, injury management and occupational consultancy services in Australia.</td>
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<tr>
<td>DFaCS</td>
<td>Department of Family and Community Services</td>
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<td>DSP</td>
<td>Disability Support Pension</td>
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<tr>
<td>JobNetwork</td>
<td>The Job Network is a national network of around 200 private, community and government organisations that compete to help individuals find the right the job.</td>
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<td>JPET</td>
<td>Job Placement, Employment and Training – A support referral service for students and job seekers aged 15-21 years. Can provide support to people who may be homeless or having drug alcohol issues.</td>
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<td>JPP</td>
<td>Job Pathway Program – Helps young school leavers find jobs and provide monitoring support for up to 12 months.</td>
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<td>JSCI</td>
<td>Job Seeker Classification Index</td>
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<tr>
<td>Open employment</td>
<td>Clients are found employment in the open labour market and are supported by staff from a Department of Family and Community Services funded open employment service. Levels of support are varied according to individual need.</td>
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<tr>
<td>Supported employment</td>
<td>Clients are usually employed by the same agency that provides support. Hours of employment may be variable and are often less than full-time. Employment may be in specialist business services or in mobile work crews or enclaves (small groups of people with disabilities who work in specialist units within a commercial business).</td>
</tr>
<tr>
<td>Transitional employment</td>
<td>Transitional employment services offer the recovering person a series of transitional experiences from pre-vocational training to time limited supported work experience and eventually open employment.</td>
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<td>WATs</td>
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References


