Workforce participation by people with mental illness

**Submission to the Victorian Government's
Family and Community Development Committee**

Victorian Mental Health Carers Network Inc

November 2011

Introduction

The Victorian Mental Health Carers Network (VMHCN) is the peak body for carers of people with mental illness in Victoria. A key role for the Network is to bring the voice of carers to government and to provide a link for government to carers. Its membership comprises organisations (with some focus in their work on carers of people with mental illness) and individual carers and carer-focussed workers. Through the Network, members share information, discuss policy issues, carer problems, initiatives. VMHCN administers the Carer Support Fund (the Victorian Government's scheme for providing financial support for carers in need). It has a small research and evaluation unit, working alongside VMIAC on consumer and carer experience of care and promoting consumer and carer participation in improving service delivery, and a small training unit, focussing on training for the peer workforce and on training mental health professionals to work with families.

VMHCN is pleased to provide a response to the Family and Community Development Committee on the important subject of workforce participation by people with mental illness. We present our views below within the framework of the specific questions set out in the Submission Guide for this inquiry, but would like to make a few introductory comments:

- There is much discussion these days in the mental health sector on taking a recovery-based approach. In the context of mental illness, recovery does not imply cure. A recovery focus involves working with people to manage the symptoms of their illness, to build their confidence and self-identity and to help them to connect with the community and gain education, housing and employment. Appropriate employment is a matter of great importance to people with mental illness; it must be a key factor in a recovery program.
- Carers play a critical role in supporting a consumer's efforts to find and stay in suitable work. The demands on carers are huge and very stressful (both in this effort and in the wide range of other caring activities). Caring has an immense impact on their lives (including their own workforce participation as well as their health and general well-being and finances). Because they are so closely involved, carers have great insight into the issues involved, the barriers, challenges and needs of consumers entering or trying to maintain employment.
- Involving carers in efforts to improve workforce participation of the people they care for is a topic of prime importance. Carers must be part of a team with staff from mental health services and employment services – they have a lot to offer the team and also need to know what is being planned and implemented so they can be effective in supporting the plans.
- Consumers and carers are a very diverse "community". Any initiatives related to the subject of this inquiry must respond to the different needs of consumers and carers in different cultural, age, geographical and socio-economic groups. .This issue is not covered in any detail in this submission, but VMHCN could facilitate preparation of material on this topic if that would be useful to the Committee.

The subject of this enquiry is not a topic on which VMHCN has done specific research and we are not a service-deliverer in this area. However, as carers we know the great importance of social inclusion, including appropriate employment, for the health and recovery of those who have suffered from mental illness. This submission reflects the understanding and views of a number of our members, carers and members of carer-focussed organisations, who bring to the table many years of caring experience and of work in the mental health sector.

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Q What are the key features of mental illness that need to be understood in the context of workforce participation?

Those involved need to understand the features that are pertinent <u>for each individual in question</u> (the features vary very greatly from person to person), and so they need to understand:

- Wide range of illness types and of their symptoms
- Nature of treatments and possibilities for improvement, for "recovery"
- Episodic nature of illnesses, chance of relapse
- Impact of illness and medication on physical, mental & social capabilities (when ill, when in treatment, when well)
- Fact that intellectual capacity may not be affected
- That illness can develop under stress or after trauma, but also for some people with no apparent external cause or "trigger"
- That workplace environments have their own psychological risk factors that can contribute to the development of a mental illness or exasperate existing and perhaps dormant mental illness as well as hinder a healthy return-to-work process. A workplace must have a reasonable level of mental health literacy to understand the actions and behaviours required to support those with mental illness, remembering that many people choose not to disclose their mental illnesses to their employers for an array of reasons.

> "An unhealthy work environment or a workplace incident can cause considerable stress and exacerbate or contribute to, the development of a mental illness. Research indicates that 'job stress' and other work related psychosocial hazards are emerging as the leading contributor to the burden of occupational disease and injury". (Source: LaMontagne AD, Keegel T & Vallance D (2007) Protecting and Promoting Mental Health in the Workplace: Developing a Systems Approach to Job Stress, Health Promotion Journal of Australia 2007,18, 221–8 , citing Marmot M, Siegrist J & Theorell T (2006) Health and the Psychological Environment at Work, Social Determinants of Health 2006, 97–130)

In dealing with a particular consumer, those involved need to understand:

- Impact of the illness, status of treatment, effects of medication
- Nature of an individual's dependence on support, on care, on carer(s), on stable housing
- Strengths and abilities, level of motivation and the meaning of work for that individual
- The individual's education and employment background
- Knowledge of this individual's early warning signs
- Contact details for carer/family members

Q What are the rates of participation by people with mental illness in the workforce and how do these rates differ for high and low prevalence mental illnesses?

It is well-documented that the rates are much lower than for the population as a whole, much lower than for people with a physical disability. Some statistics are available, but are likely to be of limited coverage – *eg* may be looking only at people currently in treatment in clinical services, or at people on disability pension etc. The full story is much greater than that – those not receiving treatment, those receiving treatment from private practitioners, those in recovery, those not on disability support, those not disclosing. In considering any statistics, one needs to know how they have been derived and they should always be so qualified.

Comments from carers and workers indicate that people (including carers themselves) who experience high prevalence disorders (eg depression and anxiety) are largely overlooked and are in the "hidden" percentage. This is a group of people who usually do not seek treatment, are not involved in clinical mental health services and have a high number of "stress leave" absences from work.

> A total of 3.2 days per worker are lost each year through workplace stress. (Source: Work Outcomes Research Cost Benefit Project, preliminary data, Mental Health Fact Sheet: Mental Health and Employment, MHCA)

Q What capacity do people with mental illness have to participate in the workforce?

The range of intellectual and physical capability of people with mental illness is as great as in the population as a whole, and their capacity to participate is much greater than is generally recognised. .

A small percentage suffer so much from their illness that work may not possible for them a good deal of the time, but most have some capacity most of the time. In recent times, thankfully there has been considerable publicity about high-profile and high-performing individuals who suffer from mental illness; their capacity may be reduced temporarily by their illness, but they can often return successfully to their previous roles. The same is true of many not-so-prominent "ordinary" members of our community. Much that is written on the topic of workforce participation of people with mental illness relates to people who have "fallen through the cracks", probably from a relatively young age, and whose capacity to participate in the workplace has been severely eroded. They certainly need much support and the emphasis there may well be justified, but there is a much wider picture to consider *eg* many people well into tertiary education or into good careers are hit by mental illness and need support in recovery.

Q To what extent do people with mental illness want to participate in the workforce?

Most people with mental illness know that positive work experience brings satisfaction, a degree of independence, social interaction, self esteem, increased self confidence, a feeling of self-worth and pride, some level of financial independence and a chance to be part of the community. Their desire to work is greater than is generally recognised. Sadly, a few have been so discouraged by their interactions with health and employment services, or by unfortunate experiences in the workforce, that they do not want to pursue any work opportunities. Some are nervous about the stresses associated with work, perhaps encouraged in this direction by the attitudes of health professionals or of their families/carers. But all the evidence is that a large majority want to work.

Q What are the costs of low workforce participation rates by people with mental illness?

- Costs to the individual come first – low esteem, low income, social isolation, dependence, greater chance of relapse (including psychiatric crisis and suicide), poor physical health, greater chance of resorting to drugs
- Costs to carers are enormous – emotional, time, financial

Some research suggests that high prevalence disorders result in greater total costs and harm to individuals, families and communities than do low prevalence disorders.

- Direct costs to the community – greater demand on mental health services, support pensions and other state-funded community services (justice, housing, homelessness, drug and alcohol)
- Lost costs to the community – others have looked at this in some detail and presented estimates to previous enquiries. No doubt the Committee will be provided with relevant information in other submissions.

Q What practical strategies can be implemented to work towards minimising these costs?

All the elements of the answer to "How can we get people into work (and keep them there)?" are obviously important in minimising these costs. In addition, development of mental health literacy in the workplace is a critical response to this question – understanding the actions and behaviours required to support those with mental illness, remembering that many choose not to disclose their condition. Employers need to be as informed about mental health risks just as they are on other OH&S risks; businesses need to have a in-depth understanding of mental health information; they need insight as well as strategic and systemic processes in place to support people with illness, thus ultimately minimising costs. Participation in this area be mandatory for all those who direct, manage and supervise others, not only in discrete parts of businesses such as OH&S, HR etc.

Q In what ways does workforce participation by people with mental illness provide benefits at an individual, societal and economic level?

- Individual – esteem, confidence, finance, independence, social interaction, routine and purpose in life, better mental and physical health
- Carers – relief from a little of the stresses of caring; renewal of a sense of hope, less financial demands
- Society – reward from the efforts of those working, in manufacture, services, education, government, etc
- Economic – returns to employers, taxes to government, reduction in health costs

Q What are the barriers experienced by people with mental illness seeking to participate in the workforce?

- For some, a loss of confidence in facing employment after suffering from mental illness.
- Community attitudes reflected by employers – the stigma of mental illness persists and the mere disclosure of mental illness often sees the door closed.
- Employers and employment services (including disability employment services as well as the general recruitment and placement industry) not understanding mental illness, making negative assumptions about capacity, considering only low-level jobs. Hence lack of opportunities, or lack of appropriate opportunities. Going through a disability employment service can have a very negative impact on workers who have previously held down roles with considerable responsibility and authority and/or seniority.
- In the workplace, covert behaviours and prejudices of managers and colleagues, saying they are supportive but not offering real opportunities that may have been put forth prior to a person's illness
- Lack of knowledge (in consumers and carers) of disability employment services.
- Mental health staff not concerning themselves with employment ambitions/needs, not seeing that as part of their role and not being knowledgeable about employment services, being overly focussed on diagnosis and symptoms, not appreciating the importance of employment in their client's recovery.
- Mental health staff inadvisably discouraging patients from seeking employment because of negative perceptions of consumers' ability.
- Employment services staff not being familiar with mental illness issues (illness types, medication, support needs etc) and not being familiar with mental health services. As a result, in some cases, employment consultants deal with persons with mental illness in inappropriate and even unprofessional ways.
- Exclusion of carers from plans in relation to employment. Employment consultants are often unwilling to deal with carers or even to have them present at interviews with the consumers. Carers can provide great support to consumers entering or maintaining employment if they are involved in treatment and care planning and decision making. Carers also can provide excellent information to service providers as they have close contact with the consumers.
- Lack of coordination and communication between mental health and employment services.
- Sometimes carers/family discouraging consumers because of concern that work stress may be bad for their loved ones' mental health. In most cases, the reality is that the stress of being unemployed is greater than the stress of working.
- Consumers themselves carrying that same stigma, convinced that they are not capable of holding a job.
- Reduced ability, caused by the illness and/or medication, in the skills required when pursuing work (seeking opportunities, presenting well, interviews, time-keeping and transport arrangements can all be difficult). People with mental illness need great support. Often the support available from and offered by families is ignored or rejected, both by mental health services and employment services.
- Interruption to a consumer's education caused by mental illness.
- Gaps in a consumer's job history caused by illness – seeing this, employers may be unwilling to risk such interruptions.
- Concern (of consumers and carers) about losing the benefits of disability pension and health benefits (so important in covering the costs of medication) and about not being able to get back on pension support in the event of a serious relapse.
- The need to report sporadic or irregular income to Centrelink.
- Long-winded assessment and preparation programs – consumers can just lose heart. Employability assessment tools and methodologies mandated by the disability employment services often do not align with the individual work goals and preferences of consumers.
- Emphasis on pre-vocational programs instead of rapid assessment and action.
- Requirement of ability to work eight hours a week to access DES services – this is too much initially for some consumers.
- Lack of intense long-term support for consumers who are employed.
- Day-time hours worked by continuing care teams at clinical services – consumers in work have difficulty getting to appointments.

Q How can workforce participation by people with mental illness be most effectively enabled?

- Integrate employment services with health services and follow all the principles of IPS – Individual Placement and Support. Place employment consultants in clinical and community mental health services, working in teams with mental health professionals.

  IPS principles:
  - The goal is open, competitive employment – this requires approaches that directly help the person to get and keep a job
  - Eligibility is based on consumer choice – the person's desire to work is the main criteria for acceptance into a program
  - Rapid job search is used within four weeks – skills training occurs on the job or concurrently with employment
  - Employment assistance is co-located with treatment - this approach enables better engagement of the person into the employment service. Communication between the clinical case manager and the employment specialist is enhanced, with clinicians supporting work plans and employment specialists able to include clinical information
  - Job searches are based on the individual's preferences and skills
  - Personalised benefits planning is provided – the employment specialist works with the person to plan the impact of employment on income support and entitlements; and
  - Ongoing support is provided during employment – this recognises the episodic nature of mental illness and provides support when workplace demands change.

  This approach is supported by a strong body of international research and over the last few years has been shown to be effective in a number of local programs [MIF-Goulburn, MIND-Wangaratta, Orygen, Sacred Heart Mission J2SI, Forensicare, Ostara, NSW VETE program].
- Establish a system that supports people with mental illness regardless of how many hours they can work. Starting with just a few hours a week is the right thing for some people.
- Train mental health staff in employment matters (benefits to their patients, services available), require them to be involved in this area and make success of their patients in finding and keeping work an important performance indicator. Specifically, require staff to talk with consumers about employment as an integral part of treatment, from the beginning, to take an indication of interest as the main criterion for getting on immediately with the search for employment, then to provide very close support in the search and when a position is taken, developing a plan to identify and respond to early warning signs of deterioration in the consumer's mental health.
- Provide long-term, intense support to those in work, tailored to their individual needs. Where the consumer has disclosed his or her illness to the employer, this support could extend to the employer and work colleagues supporting the consumer and coping with any deterioration in the consumer's mental health. Peer workers in the Central North Adelaide Health Service use "Ulysses Agreements" (like Advance Directives), so that nominated holders of such an Agreement know what to do and what not to do if a person begins to display symptoms of their illness at work.
- Provide the best possible mental health treatment to all who need it – the better one's mental health the greater the chance of success in seeking and keeping work. Today's mental health services are overloaded and crisis-driven, so there are many stories of people in need of help not being admitted as patients or being discharged too soon.
- Train employment service personnel in how to work with people with mental illness – the limitations it can bring (time-keeping, transport, pressure, appearance), its varied nature, possible episodic occurrence, the support that is needed.
- Educate families and carers so that they recognise the benefits of employment to their loved ones.
- Involve families and carers who want to help; recognise that a person with mental illness needs a lot of support and welcome what carers bring; find out what support each carer is providing and look for ways to supplement that or, if desirable, to replace it, with professional service.
- Provide counselling for consumers and carers on social security matters and management of personal finances. Mildura Base Hospital has a financial counsellor onsite once a week, available for patients, carers and the broader community. This works very well and they are exploring the possibility of getting a similar presence from Centrelink. They would do well to consider similar links with an employment service.
- Provide incentives for organisations to provide employment with sufficient support and flexibility. Employment of a person with a mental illness may require some staff time to ensure

the person receives sufficient support and supervision, particularly if they are entering the work force for the first time or are returning after an episode of illness. Funding to assist with provision of this extra support would be helpful.

- Train employers (this must include all workers and supervisors, not just managers or HR personnel) in mental illness [SANE's Mindful Employer, MIF programs, VPS Open Minds, Healthy Minds Return to Work programs, Mental Health First Aid programs] and provide long-term incentives. Here the aim needs to be both to improve the opportunities for new recruits with mental illness as well as to establish an environment that supports employees who develop a mental illness. Don't think just about how to find jobs for those who are ill and out of work, but also how to help those who become ill to retain their existing positions. Government departments should lead the way – there is no excuse for them not to be good employers of people with mental illness. There are many stories even of mental health services that don't provide a supportive, healthy environment for their employees – too much stress, pressure, bullying.
- Set up peer support positions and encourage operation of support groups in the work place, for both mental health consumers and carers.
- Provide flexibility within the work environment so that episodes of illness can be accommodated and employment is not lost as a result of relapse or ill health. Provide flexible work arrangements to allow consumers to attend and carers to assist at medical or other treatment appointments. Allow additional leave, on an as-needs basis, again for both consumers and carers.
- Support consumers' attendance at counselling, with psychologists, or in other courses of treatment to enable them to stay at work; extend the operating hours of continuing care teams set up by clinical services, to facilitate attendance by consumers after work hours.
- Set up arrangements for consumers coming back to the workforce that allow gradual increases in work hours. The Peer Work Program run by MIFSA does this and has proved to be a good way to get people back into employment – people with mental illness and the program coordinators can assess 'readiness' for return to the workforce. Employment in the peer workforce can be a stepping-stone to mainstream employment
- Provide government support to organisations that are setting up "social firms". These businesses provide the most suitable environment for some people with severe illness and/or long-term unemployment and so have an important role to play. They are most rewarding when they have a structured approach which extends to the consumer being assisted (on an optional basis) to pursue employment in the open market. No doubt the Committee will hear details of the work of Social Firms Australia, MIF ventures and ERMHA's Mad Cap Cafe.

Q In what ways do the roles of Commonwealth, State and Local Government intersect in the context of workforce participation by people with mental illness? How effective is cross-government collaboration? Q What whole of government approaches need to be considered in enabling workforce participation by people with mental illness?

The prime issue here is that federal government is responsible for employment and disability support, while state government is responsible for mental health services. More than collaboration– integration, merging, overlap - is required, not just to make it more practicable for the consumer and carer to access these services, but to make the services effective, to make them work. There have been some recent moves in this direction in a few services (*eg* DESs specialising in mental illness, some employment personnel working within teams in a few clinical and community mental health services), but overall carers are still telling us that health professionals take no interest in employment and that employment agencies handle people with mental illnesses in very inappropriate ways.

Q Is there a stronger role for local government in promoting the workforce participation of people with mental illness? What would this look like?

Local government, along with other potential employers, could be given incentives to take on people with a mental illness in appropriate roles. Local government should also ensure that they have systems in place to support and assist anyone already employed in the service who has a mental illness.

Q In what ways do workplace practices influence participation in employment by people with mental illness?

Stigma is a big issue – attitudes of recruitment officers, of managers and supervisors, of other worker can all inhibit entry or retention. I hope you hear some positives from the experience of MIF working with employees and managers in Telstra and Kodak.

Our comments above on mental health literacy are very relevant here. Busy, high stress workplaces may not always be well placed to provide the support that is needed by an individual with a mental illness. Managers need training to ensure they are attuned to the difficulties that may be faced by an employee with a mental illness and in turn are able to train staff to respond appropriately.

> Despite one in five Australians experiencing mental health problems each year, nearly half of all senior managers believe none of their workers will experience a mental health problem at work. (Source: Hilton, Whiteford, Sheridan, Cleary, Chant, Wang, Kessler (2008). The Prevalence of Psychological Distress in Employees and Associated Occupational Risk Factors)

Q How can business effectively support people with mental illness in the workplace?

- Policy development for supporting people with mental illness (this is often weak *cf* policies for physical disability) and publication of a supportive policy
- Training for all personnel about mental illness and company policy and legal framework. Run campaigns and make this a regular business activity
- MIF approach to working with employers and SANE "Mindful Employer" program

A range of other initiatives could support improved workplace practices:

- Provide flexible working arrangements, in particular to allow for some of the possible effects of medications; *eg* it may take time for a consumer to "kick in" in the morning and travel to work may be difficult, so a later start time for work may be needed
- Run more of the beneficial Mental Health First Aid courses in mainstream workplaces, possibly with an employee with mental illness as a resource for the facilitators.
- Create a minimum requirement of mental health first aiders in the workplace similar to that for general first aiders.
- Skill up identified personnel in the capabilities of conversation skills that support those with mental illness at work
- Stamp out any harassment and bullying behaviours that can contribute to psychological injury risks
- Offer speaking opportunities for those that have the confidence to talk about their successful recovery from mental illness in their own workplaces.

Q What role do unions have in the context of mental illness and workforce participation?

- Training and awareness-raising as a first step
- Unions have a role in protecting workers' rights under legislation related to discrimination and violation of human rights.
- Employees should be advised of the appropriate union for their occupation level.

Q How can carers, friends and colleagues be assisted in their role in supporting people with mental illness in workforce participation?

- As necessary, provide information about the beneficial impact of employment on the consumer's recovery. Clinical and community-based mental health services could run workshops for consumers and carers to raise awareness and provide hope. Follow-up programs would need to be put in place to sustain the momentum and uptake.
- Include carers in all treatment & care planning, including discussion of employment possibilities. Seek information from carers, friends and colleagues (with permission) that may be of assistance in making employment plans and arrangements for the consumer. Ensure that carers have information needed for them to be effective in their caring role.
- Ensure the employer has contact details for family, carers, friends as appropriate
- As above, find out what support each carer is providing and look for ways to supplement that or if desirable, replace it, with professional service. Be respectful of the needs and situation of the carer.

- Recognise the problems that carers of those suffering with mental illness have in being able to fully participate in the workplace, simply because of the demands of their caring role. Anecdotal evidence suggests people are less likely to put their hands up for time off work for mental health caring roles than for physical health caring roles.
- Recognise that many carers suffer themselves, particularly from the high prevalence disorders (anxiety, depression etc), may not acknowledge their condition and may not seek medical support. There is a call for attention to respond to the needs of such people to support their own workforce participation.

Q What role can peer support provide in the workforce participation of people with mental illness?

Sharing of experiences with peers can be most helpful in preventing problems, overcoming difficulties and building confidence.

<u>Taking peers to refer to those with experience of mental illness</u> ......Peer support – either from consumer and/or carer consultants, from peer-support groups in mental health services or from community-based support groups - can provide great advice and encouragement to people with mental illness and their carers as the consumers strive to find work or to stay in employment. In the workshops mentioned above, employed consumers could talk of their successes, however small. Note the valuable contribution made by the "Open Minds" group in the Victorian Public Service.

<u>On the other hand, taking peers to refer to a group of colleagues in a workplace</u> .... It can be useful to arrange a facilitated consultative meeting to educate the staff on all of the day-to-day activities that contribute to a healthy psychological environment, discuss any areas that need adjustment and create strategies to meet these identified needs. This is beneficial for all staff and should not be set up to single out any member of the staff regardless of their mental health status.

Q Into the future, what role should specialist mental health services assume in supporting workforce participation by people with mental illness?

The IPS process is a proven methodology for integrating employment services with mental health services and providing appropriate support. It should be applied in adult clinical services, in youth services (for education or employment) and throughout the PDRS sector.

A cultural change is required to develop a strong role for mental health services in supporting the workforce participation ambitions of their clients and in liaising with employment services and the broader recruitment and placement industry. Some of this has been covered above - learning about a consumer's education and employment background and very early discussion of ambitions for continuing education, continuing employment or new directions should be a routine. Then a plan should be developed with each consumer and his or her carer(s) to meet those ambitions and provide whatever support is necessary. These new directions should be adequately resourced and not simply added to existing staff workloads.

The Submission Guide for this enquiry refers to mental health services being involved in early intervention initiatives. Of course, if these can reduce the incidence of mental illness, there will be an indirect impact on workforce participation, but most carers believe that such initiatives will have only a small effect on the incidence of severe illnesses.

Q Do other health and community services have a role in supporting workforce participation by people with mental illness? What should this look like?

The PDRS sector in Victoria is ideally placed to provide continuing support for workforce participation. Again, this should be an integrated part of the service they provide, preferably achieved by placing employment consultants within their service teams. There are some good examples in the sector; funding should be provided for all services to follow these leads.

Q What types of employment programs are most beneficial in supporting workforce participation by people with mental illness? This is covered above – there is no doubt that an integrated approach, with the key elements of the IPS method, is most beneficial. The supportive environment of "social firms" makes this approach the best for some consumers. The Peer Work Program run by MIFSA is also a successful model.

Q What education and training programs are most effective in the career development of people with mental illness?

Considering training for those people with mental illness:

- Return to Work program run by Healthy Minds
- Some programs for consumer/carer peer workforce.
- Training/education programs need to have flexibility to accommodate episodes of illness. Support Should be built in to assist consumers to catch up on areas missed due to ill health. It would be helpful if a person did not lose their place in a course or were not recorded as "fail" due to ill health.

and more general training:

- As well as programs that would normally be offered to the general workplace population at the various junctures of career progression, specialist subjects that support a strong psychological workplace environment would provide a valuable complement; for example: resilience programs, emotional intelligence programs, social intelligence training and development, programs for building strong relationships at work and all other programs that have self reflection and self awareness as central to the outcomes.

Q What role should mental health services assume in employment, education and training programs.

As above, defining and providing support for consumers' education, training and employment needs should be an integral part of the service received by a client of the mental health services. As with employment, an integrated (IPS-type) approach is required. The PDRS sector is well-placed to enable clients to attend educational programs – facilitating enrolment, encouraging attendance and completion, even attending classes with clients.

Q What are the top 3 priorities for achieving improved outcomes for people with mental illness seeking to participate in the workforce?

1. Place employment consultants in mental health services and have them involved from the very early stages of treatment, working with consumers, carers and clinicians. Minimise assessment requirements. (Are job capacity assessments for people with mental illness valid? Make consumer wishes the prime criterion). Begin job search and placement as quickly as possible
2. Work with employers to increase understanding and support of people with mental illness in the workplace, especially by policy development and training of all personnel.
3. Review the issues faced by people with mental illness who receive disability support pensions as they consider entering the workforce – loss of income, loss of health benefits, risk of not being able to return to disability support in the case of relapse. It is acknowledged that the federal government's 2008 decision to drop the requirement for a full eligibility review for DSP recipients who wanted to access employment services did remove one disincentive, but carers still tell us that they and consumers are very nervous about transferring from DSP to employment.

Closing remarks

- It would be useful to extend this inquiry to include workforce participation of carers of people with mental illness. Priority 3 in the National Carer Strategy recognises the importance of action in this area.

- It is crucial to include carers as part of the team which is assisting a consumer to return to or remain in employment. (This could very well have been in our top three priorities.)

The submission by Carers NSW to the current federal enquiry and the transcript of their presentation provide excellent material on these two topics. VMHCN urges the Committee to review this material, especially the presentation by and discussion with a carer.

On the second point, the Carers NSW submission includes these paragraphs:

Carers should be recognised, included and supported in the delivery of employment assistance to people with a mental illness. The *Statement for Australia's Carers* should inform the delivery of disability employment services, including that:

6. The relationship between carers and the persons for whom they care should be recognised and respected.
7. Carers should be considered as partners with other care providers in the provision of care, acknowledging the unique knowledge and experience of carers.
8. Carers should be treated with dignity and respect.

The experiences of [carers] suggest that these principles are rarely upheld by disability employment services. On the contrary, carers are generally excluded by employment services. This is an issue that needs to be addressed by the Committee in any analysis or recommendations to be made relating to the delivery of employment assistance to people with a mental illness.

The benefits of including carers and their expertise to the carer, the person they support, and to service providers are considerable. Carers have a unique insight into the needs and experiences of the person they care for. They are often the main source of support to people with a mental illness, and should be included and informed to ensure that they are able to effectively support the person's participation in employment services, their individual support plan, and any goals or action plans they have developed. This may be support in the form of encouragement and emotional support, or it may be the provision of practical support such as transport to job interviews or training programs.

Carers often have a pivotal role in organising services and gaining access to the services needed by the person they care for. Seventy-seven per cent of respondents to the *2010 Mental Health Carers Survey* indicated that they were responsible for organising the majority of care for the person they care for. It is illogical for carers to be systematically excluded from employment services when in so many cases they have such a significant role regardless of whether the employment service includes them or not. It is better for all concerned that the carer is included, and the person with a mental illness, the employment service, the carer and any other services providing support work together.

Carers can be included in the delivery of employment services without violating any rights of the person with a mental illness. Too often in the mental health sector, concerns (that are often uninformed or unfounded) regarding confidentiality result in the automatic exclusion of carers. It is important that carers are included in an appropriate, legal and ethical manner, with the permission and knowledge of the client, without infringing upon the rights of the carer, or overly increasing the care responsibilities they are already balancing with their own life and other responsibilities.

- Finally, VMHCN feels obliged to convey one message that has come through to us very clearly. Carers are not pleased to be asked to respond to yet another inquiry on this topic. They desperately want state and federal governments to take action, to take some initiatives, to fund programs that are known to work, then to come and talk to carers about what new things are being done and whether they are succeeding. There has been so much recent work on this topic to which carers and consumers have been asked to contribute. They wonder why another inquiry is necessary. They remember very recent work on:
  - The current federal enquiry; many submissions and interview transcripts are available on the internet. As one of our members has said : "What more is there to say?"
  - National Mental Health and Disability Employment Strategy 2009
  - DEEWR Literature Review 2008 "Employment assistance for people with mental illness"
  - Fourth National Mental Health Plan, which said: *Coordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs*
  - The paper "Reforming Welfare to Work" by Welfare to Work Reform Collaboration 2008

- A report to Minister Neville in September 2010 by a sub-committee of the Victorian Ministerial Advisory Committee on Mental Health – an excellent report based on some 12 months' work and many interviews.

For over a decade, in fact, there have been such policies, papers and strategies in Australia which pertain to mental health and employment, for example, the National Mental Health Strategy's 2002 paper on Employment and Psychosis: **.**

- 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.

- 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.

- 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.

The National Mental Health Strategy and various editions of the National Action Plan on Mental Health have emphasised delivering connected services to people with a mental illness and recognised the challenge of getting different services such as disability support, housing, education and employment to work together. While there are numerous reports, plans and strategies, real action to address the social and economic marginalisation of people with a mental illness is yet to eventuate.