Mental Health and Work

AUSTRALIA

OECD

Mental Health and Work: Australia

Please cite this publication as:
OECD (2015), *Mental Health and Work: Australia*, Mental Health and Work, OECD Publishing, Paris.
http://dx.doi.org/10.1787/9789264246591-en

ISBN 978-92-64-24658-4 (print)
ISBN 978-92-64-24659-1 (PDF)

Series: Mental Health and Work
ISSN 2225-7977 (print)
ISSN 2225-7985 (online)

Revised version, February 2016
Details of revisions available at:
http://www.oecd.org/about/publishing/Corrigendum-Mental-Health-Australia.pdf

Photo credits: Cover © Inmagine ltd.

Corrigenda to OECD publications may be found on line at:
www.oecd.org/about/publishing/corrigenda.htm.

Foreword

The mental health of the working-age population is becoming a key issue in labour market and social policies in many OECD countries. It has been neglected for too long despite the high – and growing – cost of poor mental health to people and society at large. Now, however, OECD governments increasingly recognise that policy has a major role to play in improving the employment opportunities for people with mental ill-health – particularly among the young. Policies should also seek to support employees who struggle in their jobs and help them avoid long-term sickness and disability caused by mental disorders.

A first OECD report on the subject – *Sick on the Job? Myths and Realities about Mental Health and Work*, published in January 2012 – identified the main policy challenges for OECD countries by broadening the evidence base and questioning some of the myths that surround the links between mental ill-health and work.

This report on Australia is the last in a series that looks at how selected OECD countries address those policy challenges. Through the lenses of mental health and work, it covers issues such as the transition from education to employment, the workplace, employment services for jobseekers, the drift into permanent disability, and the capacity of the health system.

The other reports in the series consider the situations in Austria, Belgium, Denmark, the Netherlands, Norway, Sweden, Switzerland, and the United Kingdom. Together, all nine reports endeavour to deepen the evidence on good mental health and work policy. They also contain a series of detailed country-specific policy recommendations.

This review is the work of OECD's Directorate for Employment, Labour and Social Affairs. Iris Arends and Veerle Miranda (from the OECD) and Lesley Wilkinson (seconded to the OECD from the Australian Department of Employment) prepared the report, under the supervision of Christopher Prinz. Dana Blumin and Agnès Puymoyen carried out the statistical work. Natalie Corry provided project assistance and Ken Kincaid edited the report. Valuable comments were provided by Mark Keese and Stefano Scarpetta. The report also includes comments from a large number of Australian experts, ministries and organisations.

Table of contents

Figures

Tables

Acronyms and abbreviations

ACARA	Assessment and Reporting Authority
ADE	Australia Disability Enterprises
AHRC	Australian Human Rights Commission
AIHW	Australian Institute of Health and Welfare
ATAPS	Access to Allied Psychological Services
BEACH	Bettering the Evaluation and Care of Health
CBT	Cognitive Behavioural Therapy
CIDI	Composite International Diagnostic Interview
COAG	Council of Australian Governments
DDA	Disability Discrimination Act
DEEWR	Department of Education, Employment and Workplace Relations
DES	Disability Employment Services
DES-DMS	Disability Employment Services – Disability Management Service
DES-ESS	Disability Employment Services – Employment Support Service
DSP	Disability Support Pension
EAF	Employment Assistance Fund
EAP	Employee Assistance Programme
ECEC	Early Childhood and Education Centres
ESAt	Employment Services Assessment
ESL	Early school leavers

FPS ST	Focussed Psychological Strategies Skills Training
GDP	Gross domestic product
GFC	Global financial crisis
GP	General practitioner
GPMHSC	General Practice Mental Health Standards Collaboration
HILDA	Household, Income and Labour Dynamics in Australia
HWS	Health and Work Service
ICD	International Classification of Diseases
IAPT	Improving Access to Psychological Therapies
IPI	Income Protection Insurance
IPS	Individual Placement and Support
ISCED	International Standard Classification of Education
JSA	Job Services Australia
JSCI	Job Seeker Classification Instrument
LHN	Local Hospital Networks
MBS	Medicare Benefit Schedule
MEAST	Maximising Engagement, Attainment and Successful Transitions
MHNIP	Mental Health Nurse Incentive Program
MHST	Mental Health Skills Training
NEET	Not in Employment, Education or Training
NGO	Non-Governmental Organisation
NHS	National Health System
NSA	Newstart Allowance
NSMHWB	National Survey of Mental Health and Wellbeing
PHaMs	Personal Helpers and Mentors
PHN	Primary Health Networks
PHO	Primary Health Organisation
PIR	Partners in Recovery

PLC	Positive Learning Centres
PP	Parenting Payment
PSC	Psychological Safety Climate
SDQ	Strengths and Difficulties Questionnaire
SF-36	Medical Outcomes Study Short-Form General Health Survey
L&ST	Learning and Support Team
SME	Small and Medium-sized Enterprise
SWA	Safe Work Australia
SWS	Supported Wage System
TAFE	Technical and Further Education
VET	Vocational Education and Training
WHO	World Health Organization
WHS	Work Health and Safety
WMH-CIDI	World Mental Health Composite International Diagnostic Interview
YA	Youth Allowance

Executive summary

Throughout the OECD, there is growing recognition that mental health is a major issue for social and labour market policies. Mental illness exacts a heavy price on people, employers, and the economy at large, affecting wellbeing and employment, and causing substantial productivity losses.

Policy thinking in Australia shows well advanced awareness both of the costs of mental illness for society as a whole and of the mental health benefits of employment. Both government and non-government bodies organise awareness-raising initiatives, invest in promoting mental health among pupils in schools, seek to improve access to mental health care among people with mild-to-moderate mental disorders, and provide employment services to reactivate people with mental health problems who lost their job.

However, the fragmented nature of policy initiatives and the lack of continuity in government funding hinder the country's ability to improve labour market and social outcomes among workers who suffer from mental ill-health. A more structured approach is required to: make employment issues a concern of the health care services; help young people succeed in their future working lives; make the workplace a safe, supportive psychosocial environment; and better design and target employment services for jobseekers with mental ill-health.

In this context, the main OECD recommendations to Australian policy makers are as follows:

- Develop employment-oriented mental health care and explore ways to integrate health and employment services.
- Create a coherent nationwide support structure to act upon early school leaving and support young people with mental health problems in their transition into work.
- Strengthen the role and responsibility of employers in sickness management and be proactive in offering employees occupational health services, regardless of the work-relatedness of workers' mental health issues.
- Ensure better long-term employment outcomes for jobseekers by improving early identification of mental health problems, investing in appropriate services for all jobseekers with mental ill-health and encouraging post-placement support.

Assessment and recommendations

Mental ill-health exacts a high price on Australian society, in terms of individual well-being – at any given moment one in five Australians have a mental disorder – and high economic costs. The direct medical and non-medical costs of poor mental health are estimated to amount to 2.2% of Australia's GDP, or AUD 28.6 billion per year. Adding indirect costs, such as productivity loss or sickness absence, nearly doubles that amount.

Australia's policy thinking is advanced but effective implementation lags behind

The importance of investing in mental health has been high on the policy agenda of governments as reflected in, for example, whole-government policy declarations and measures like the 1992 National Mental Health Strategy and, more recently, the Ten Year Roadmap for National Mental Health Reform that was published in 2012. They have prompted innovative programmes and initiatives to promote mental health, such as *KidsMatter* and *MindMatters*. Access to mental health services, too, has been improved through schemes like *Access to Allied Psychological Services* and, for youth, *headspace*.

Yet, while the need for collaborative government action across the health, education and employment sectors is well understood, and some programmes have been put in place, there has been limited success to date in improving the social and labour market outcomes of people with mental health problems. Indeed, despite the strong performance of the Australian labour market (relatively little affected by the global economic and financial downturn compared to other OECD countries) people with mental health problems experience great difficulty in finding jobs and performing well in the workplace.

The employment gap between people who have mental health problems and those who do not is about 20 percentage points – a gap wider than in any of the other eight OECD countries that have been reviewed. People affected by mental ill-health are also three times more likely to be unemployed than those who have no mental health problems and are

overrepresented in all benefit schemes. And even when they do have jobs, they often struggle with more and longer periods of sickness absence and underperformance at work.

There are two main explanations for such weak outcomes: the lack of continuity in government programmes and the fragmentation of mental health and work policies and initiatives.

Promising initiatives tend to be short-lived and overall public spending falls short of actual needs. The federal government injects funds to stimulate innovation and develop new programmes, including initiatives that cross government departments and sectors. Yet, new funding is typically budget-neutral within spending categories, which means that existing measures have to be dropped or reduced in order to balance books. Moreover, new funding is often transitory: it reflects the thinking of the government of the day but does not contribute to any structural policy implementation. Such lack of continuity generates significant losses in start-up investment.

The actual system is rather fragmented and does not allow the various initiatives and programmes to fully bear their fruit. The key issues that need to be addressed include:

- Action to improve employment prospects and outcomes is not an integral part of mental health services;
- There is no coherent structure in place to monitor young people at risk of disengaging from education and no consistent approach to help them in their transition to work;
- The role and responsibilities of employers in dealing with mental health issues are undervalued;
- Too many jobseekers with mental health problems are excluded from integrated mental health and employment services.

Making employment part of mental health care

As in many other OECD countries, mental health treatment in Australia pays limited attention to employment-related issues. Mental health care providers, who include general practitioners (GPs), do not as a rule address them in their treatment plans. Similarly, clinical guidelines seldom refer to them, either. Indeed, there is no form of structural collaboration between the health care and employment sectors.

There is a clear need for proper understanding among health care providers of the interplay between mental health and work and of how to support people with mental health problems so that they can remain in work.

It is especially important that GPs should have such knowledge, as they draw up sickness certificates and all too often declare employees with mental health problems unfit for work. Early return to work, even on a part-time basis, is essential to offsetting the risk of becoming unable to work and permanently exiting the labour market.

GPs should be trained in assessing the capacity to work of people with mental health problems. Such training would improve sickness certification and reduce labour market exclusion. It could be provided, for example, as part of the core curricular training for GPs as they often have the opportunity to influence work participation through recommending reasonable adjustments in the workplace before people with mental health problems leave the workforce. Work should be seen as part of the treatment of mental health problems and not just as hindrance to recovery.

Outside primary care, a number of programmes serve as fine examples of how to bring an employment focus into mental health care. They include Partners in Recovery, Personal Helpers and Mentors, and Individual Placement and Support. At the moment these schemes are directed solely at people with severe mental disorders. Adjusting such programmes to cater for people with mild-to-moderate conditions would be an important step toward co-ordinated support for a much larger group of people.

Helping young people to succeed in their future working lives

Policies to support young people with mental health problems who struggle at school and in their transition to working life go only halfway. Australia's education system has, in fact, invested heavily in promoting mental health in schools, with positive effects on mental health literacy and wellbeing. However, it has not sought to develop a coherent support structure for young Australians who suffer from mental health problems. Such support is left up to individual schools, and so varies widely from one establishment to another, with no indication as to whether or not young people receive the right support early on.

The biggest challenge remains early school leaving. Programmes like *Youth Connections*, designed to spot early leavers and bring them back into education, were seemingly successful. Yet *Youth Connections* has been discontinued in its present form. Moreover, there is still a shortfall in investment for building a system which registers and monitors students who drop out or switch schools, and which transcends individual establishments. Without a monitoring system for early school leaving, which records both when and why young people drop out, it will always be a struggle to respond promptly and develop policies that are effective in getting pupils back to school quickly.

Related to the challenge of early school leaving is that of school-to-work transition programmes. Policy should ensure that young people get support in choosing appropriate career paths before they leave secondary education, especially so for young people with mental health problems who are more likely to drop out and become inactive. Successful schemes – such as the Beacon Model – that bring together schools, youth services and employers are already up and running on a small scale. The government could well draw on them as part of its efforts to improve its policies.

Fostering better mental health at work

Workplace mental health policy is somewhat contradictory in Australia. There is a wealth of information from governmental and non-governmental bodies on fostering good workplace-related mental health and on how to help workers with mental health problems to remain in or return to work. Some examples are the Australian Human Rights Commission's practical guide for managers on workers with mental illness, the Australasian College of Physicians' consensus statement on the health benefits of work, the Australian Public Service Commission's guide "As One Working together: promoting mental health and wellbeing at work" which aims to foster collaboration between employees and employers to promote mental health and wellbeing, and the workplace mental health literacy programmes from support groups like *beyondblue* and the Black Dog Institute. Yet, there is still no firm, binding legislation to act on such knowledge.

For a start, while Work Health and Safety legislation defines "health" as meaning physical and psychological health, it does not explicitly address psychosocial risk prevention. It is up to employers to make use of the available information services as they see fit, and it is not clear how well they do so. Indeed, data relating to general health promotion in the workplace make for discouraging reading: they suggest that only 3.6% of all employers invest in it.

Moreover, other than the workers' compensation system which helps only a small proportion of workers with mental health problems, no policy requires employers to support employees with mental health problems either at work or when they are on sick leave and want to resume work. Compared to other countries, employers' statutory sick-pay obligations are so low that it acts as a disincentive to invest in sick employees' return to work.

Nevertheless, Australian employers do commonly offer Employee Assistance Programmes (EAPs) and seem open to the idea of assuming responsibility for supporting their employees with mental health problems. The stance is hardly surprising, given the high costs of poor mental health for businesses – especially in the form of at-work productivity loss. Both

employers and employees should be given return-to-work obligations, regardless of whether or not an injury or illness is workplace-related.

However, not only is there no general sickness management system at the workplace level, there are also no government provisions to support return to work. In other OECD countries, like the United Kingdom, where occupational sickness and return-to-work management was once a weakness, governments have introduced Health and Work Services that help employees on sick leave resume work more quickly.

Improving employment services for people with mental ill-health

Australia has a unique means-tested benefit system for the most disadvantaged people, and an equally unique fully privatised employment service system. It is also one of the few OECD countries that gather mental health information on benefit claimants and focuses strongly on assessing their barriers to employment. The aim is to determine the most appropriate employment service for jobseekers, whether they are mainstream or affected by disability, and the amount of funding the provider should receive to help them back into employment.

Nevertheless, the identification of mental health problems can be further improved to ensure that adapted services are offered to all those in need. Because answering questions related to disability or medical conditions more generally is voluntary, it is very likely that people will not disclose their mental health problem in the initial interview. Strong reliance on telephone assessments also reduces the likelihood that assessors pick up any problematic behaviour.

The poor employment and education outcomes of people with mental health problems who are not entitled to the full set of employment services illustrate the need for better services, particularly as the Disability Employment Service achieves better long-term outcomes with more disadvantaged clients. Post-placement support and close and systematic collaboration of employment service providers with mental health services are particularly important for improving the likelihood of positive long-term employment outcomes among jobseekers with mental health problems.

In addition, too many such jobseekers fail to benefit from appropriate employment services, either because strict means-testing rules them out of such support, or because a medical certificate from their treating doctor exempts them permanently or temporarily from participation and job-seeking requirements. Indeed, rather than waiting until they are better, the employment services should collaborate with the mental health sector to offer them appropriate services in order to hasten their recovery and avert

long-term unemployment. Although reforms to that end will require some initial investment, the net pay-off in the medium term would be positive.

Over the past decade, reforms have improved the quality of assessments for disability benefits, strengthened the gateway onto such benefits, and encouraged people with disability who have some work capacity to participate in the labour market. However, significant numbers of people with mental disorders are still being granted a Disability Support Pension. Furthermore, it is of paramount importance that those who lose their disability benefit entitlements are given intensive reactivation support to help them find their way back into the labour market. Unless the new participation and job-seeking requirements are coupled with intensive support from the Disability Employment Service, it is unlikely that benefit recipients will ever return to work.

Summary of the main OECD recommendations for Australia

Key policy challenges	Policy recommendations
1. General Practitioners lack knowledge of the capacity to work of people with mental health problems	• Provide training to GPs in assessing the capacity to work among people with mental health problems. • Develop guidelines for GPs on sickness certification for different mental disorders which support timely return to the workplace. • Encourage and assist GPs in providing employment support to people with mental health problems. They could do so, for example, by working with employment counsellors, workplace rehabilitation specialists and occupational therapists.
2. The mental health care system does not focus on work outcomes for people with mild-to-moderate mental disorders	• Incorporate employment support in the provisions of capacity-enhancing programmes like Access to Allied Psychological Services and Better Access to Psychiatrists, Psychologists and General Practitioners. • Make quality indicators for patients' work outcomes part of mental health care quality assessments. • Explore ways of bringing together multiple sectors, services and stakeholders for people with mild-to-moderate mental disorders, as is done for those with severe mental disorders, so as to improve mental health and work outcomes for all.
3. Early school leaving and school-to-work transition lack a consistent policy approach in which young people with mental health problems are a specific target group	• Create a monitoring system for actual and potential early school leavers with a focus on mental health problems as a main risk factor for leaving school early and poor subsequent employment and social outcomes. • Implement a permanent, low-threshold support structure to reach and support young people who have drifted out of education and work, particularly those with mental health problems. • Develop school-to-work transition support within schools to support students at risk of inactivity early on – e.g. by bringing employment consultants into secondary and tertiary-level establishments. • Make use of NGOs' transition support programmes (such as the Beacon Model) in developing transition services at the state or federal level with a focus on youth with mental health problems.

Summary of the main OECD recommendations for Australia *(cont.)*

4. Psychosocial risks at work are not sufficiently addressed	• Put greater emphasis on psychosocial risks at work in Work Health and Safety legislation. • Monitor the execution of employers' psychosocial risk assessments and the development and evaluation of prevention plans. • Support employers and labour inspectors through codes of practice, guidelines and guidance material for addressing psychosocial risks.
5. Employers are not encouraged to act upon employees with mental health problems	• Encourage employers to seek support from occupational mental health services for workers with mental health problems. • Use mandatory return-to-work plans and monitor agreed actions to make employers and employees jointly responsible for early intervention when employees go sick, also when health problems are not work-related. • In addition, the government should take a proactive role in sickness management. It could try out easily accessible health and work services, in line with similar services in other OECD countries.
6. Too many jobseekers with mental health problems are excluded from employment services	• Provide tailored employment support for jobseekers with mental health problems irrespective of their benefit status because they face a high risk of long-term unemployment. • Avoid exemptions and suspensions from participation requirements for mental health problems and offer appropriate services in collaboration with the mental health sector to hasten recovery and a return to work.
7. Employment service providers do not achieve satisfactory long-term outcomes for jobseekers with a mental health problem	• Assure high quality of all assessments and add a validated mental health instrument to the Job Seeker Classification Instrument to improve early identification of mental disorders. • Encourage post-placement support in mainstream employment services to ensure sustainable, long-term employment outcomes. • Foster an integrated mental health and employment service provision by allocating additional funding as soon as a mental health issue is identified, irrespective of the funding stream a jobseeker is allocated to. • Provide intensive return-to-work support to Disability Support Pension recipients who lose their entitlement.

Chapter 1

Mental health and work challenges in Australia

This chapter builds on the findings of the 2012 OECD report Sick on the Job? *to highlight the main challenges Australia faces in the area of mental health and work. It offers an overview of the current labour market performance of people with mental health problems in Australia compared to other OECD countries, and considers their economic wellbeing. The chapter also describes the roles of the different tiers of government and other actors in Australian policy making.*

The statistical data for Israel are supplied by and under the responsibility of the relevant Israeli authorities. The use of such data by the OECD is without prejudice to the status of the Golan Heights, East Jerusalem and Israeli settlements in the West Bank under the terms of international law.

Mental ill-health throws up some major challenges to the smooth functioning of labour markets and social policies in the OECD area. Yet countries have so far failed to address them adequately – a reflection of the widespread stigma and taboos that attach to mental health – even though society pays a high price. Medibank and Nous Group (2013) estimates that direct medical costs (i.e. goods and services related to the prevention, diagnosis, and treatment of a disorder) and direct non-medical costs (non-health support like social services) account for 2.2% of GDP in Australia. However, Gustavsson et al. (2011) argue that such direct costs account for a minority 47% share of the total mental illness burden on society.[1] Indirect costs (such as under-performance at work and sickness absence) are even higher, estimated to account for 53% of the total cost. Taken together, direct and indirect costs stand at between 3% and 4.5% of GDP across OECD countries (OECD, 2015a).

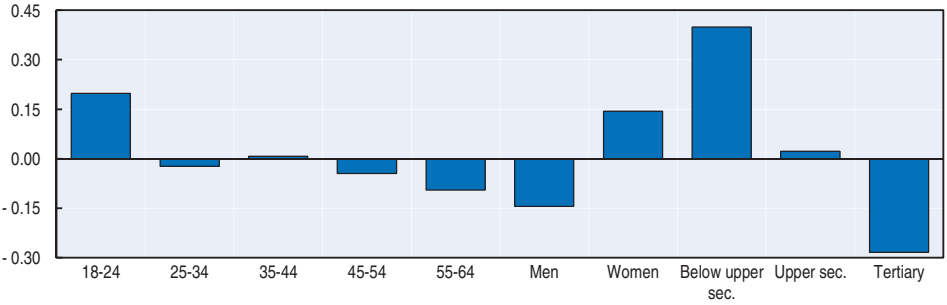
According to the recent reports *Sick on the Job?* (OECD, 2012) and *Fit Mind, Fit Job* (OECD, 2015a), policy needs to respond more effectively to the challenge of improving the labour market inclusion of people with mental illness. It should attend more closely to: mild-to-moderate mental disorders, problems that affect employed and unemployed people alike, and proactive measures to help people remain in work. Both reports draw on a number of findings, such as the sizeable employment rates among people with mental ill-health and their low productivity, and the high prevalence of poor mental health among unemployment, social assistance and disability benefit claimants.

Definitions and objectives

This report considers that a mental disorder is a condition that has crossed a clinical threshold and has been diagnosed accordingly.[2] At any given time, some 20%-25% of the working-age population in the average OECD country therefore suffer from a mental disorder (see Box 1.1), with lifetime prevalence that can be as high as 40-50%. In Australia, people with no upper-secondary schooling are much more likely to have a mental disorder than their better educated counterparts (Figure 1.1). The prevalence of mental disorders is also higher among women than men and in the age group 18-24 than in other cohorts.

Figure 1.1. **The prevalence of mental disorders in Australia varies with age, gender and the level of education**

People with a mental disorder by age group, gender and educational attainment, relative to the overall prevalence in the Australian working-age population, 2011-12



Note: "Below upper secondary" refers to Levels 0-2 in the International Standard Classification of Education (ISCED 0-2); "Upper secondary" to ISCED 3-4 and "Tertiary" to ISCED 5-6.

Source: OECD calculations based on the Australian National Health Survey, 2011-12.

StatLink http://dx.doi.org/10.1787/888933287434

Box 1.1. **Defining and measuring mental disorders**

A mental disorder is a condition which meets a set of clinical criteria that constitute a threshold. When it crosses that threshold it becomes a clinical disorder or illness that is diagnosed accordingly. Threshold criteria are drawn up by psychiatric classification systems like the Tenth Revision of the International Classification of Diseases (ICD-10), in use since the mid-1990s. (ICD-11 is scheduled for release in 2017.)

Administrative data provided by countries on clinical conditions and disability benefit recipients generally include a classification code that denotes how a patient or benefit recipient has been diagnosed. Codes are based on ICD-10 and so attest that there is a mental disorder that can be identified. Such is the practice in Australia. However, administrative data do not include detailed information on an individual's social and economic status and cover only a fraction of all people with a mental disorder.

Survey data can, by contrast, provide a wealth of information on socio-economic variables, while usually including only ***subjective*** assessments of the mental health status of the people surveyed. Nevertheless, surveys can measure the existence of a mental disorder through an instrument which consists of a set of questions on feelings and moods such as irritability, nervousness, insomnia, hopelessness, happiness, and worthlessness. For the purposes of this work, *Mental Health and Work*, the OECD drew on consistent findings from epidemiological research across member countries to classify the 20% of the population with the highest values (measured by different mental health instruments in countries' surveys) as suffering a mental disorder in a clinical sense. The top 5% of values denote "severe" disorders and the remaining 15% "mild-to-moderate" or "common" mental ill-health.

Box 1.1. **Defining and measuring mental disorders** *(cont.)*

The methodology allows comparisons across the different mental health instruments used in different surveys and countries. OECD (2012) offers a more detailed description and explanation of the approach and its possible implications. Importantly, the aim in this report on Australia, however, is to measure the social and labour market outcomes of the mentally unwell, not the prevalence of mental disorders as such. To that end, the report takes data from a number of surveys

- Australian National Health Surveys 2001, 2007-08 and 2011-12. The mental-disorder variable in the National Health Surveys is based on the Kessler Psychological Distress Scale (K10). It uses a 10-item questionnaire on emotional states experienced in the previous 30 days, such as tiredness, nervousness, hopelessness, restlessness, depression, and worthlessness. Each question has a response scale of 1 to 5. "1" = none of the time, "2" = a little of the time, "3" = some of the time, "4" = most of the time, and "5" = all of the time). The final score, which rates the respondent's psychological stress, ranges from "10" (no mental health problem) to "50" (very severe mental health problems).
- Household, Income and Labour Dynamics in Australia (HILDA) Survey, 2001-2013. The mental-disorder variable draws on the mental health and vitality scales in the Medical Outcomes Study Short-Form General Health Survey (SF-36), developed to measure quality of life and health. The HILDA mental-health variable uses nine indicators, including tiredness, nervousness, exhaustion and depression. The answer to each question is on a frequency scale of 1 to 5: "1" = all of the time, "2" = most of the time, "3" = pretty often, "4" = some of the time, and "5" = never. Total scores therefore range from "9" (severe mental health problems) to "45" (no mental health problems).

Critical to the devising of good policies that meet their objectives is understanding of some key attributes of mental illness:

- its onset at an early age,
- its varying degrees of severity,
- its persistent, chronic nature requiring ongoing support,
- high rates of recurrence requiring more intensive support at such instances,
- frequent co-occurrence with physical or other mental illnesses.

The more serious and enduring an illness is the greater is the sufferer's degree of disability and incapacity to work. The diagnosis also matters, but mental illness of any type can be severe, persistent and co-morbid. Most mental conditions fall into the mild-to-moderate category, especially those related to depression and anxiety.

One important general challenge policy makers should address is the high rates of non-awareness, non-disclosure, and non-identification of

mental illness, all of which spring from the stigma that attaches to it. Indeed, it is not always clear whether more and earlier identification improves outcomes or, conversely, increases the risk of labelling and stigmatisation. The inference is that reaching out to people with mental health problems is what matters: policies that detect but do not openly label mental illness will often work best.

The OECD (2012) has identified two main directions for reform.

1. Greater emphasis on preventing problems, identifying needs early, and intervening promptly at key stages in life – during the transition from school to work, in the workplace, and when people are about to lose their job or to slide into the benefit system.
2. A coherent cross-government approach that integrates health and employment services and, where necessary, other services that support people who suffer from mental ill-health.

This report examines how the Australian system and associated programmes and policies, on one hand, address the challenge of ensuring that mental illness does not mean exclusion from the social and economic benefits of employment and, on the other, how they translate into action upon the recognition that good work helps improve mental health. Accordingly, the report is structured as follows. This first chapter outlines the Australian context and policy thinking and compares some of the key labour market and social outcomes of people with a mental disorder in Australia with those in other countries. Chapter 2 examines the role of the health system and its interface with employment services. Chapter 3 looks at the crucial time before a young person enters the job market, while Chapter 4 goes on to consider the workplace and the role of employers. The last chapter discusses the experience of jobseekers with mental illness who enter or return to the labour market through Australia's income support system.

The Australian Government setting

Australia has three tiers of government, which make agreement on policies, programmes and services both complex and challenging for all stakeholders.

The three tiers, or three governments, are:

1. The Federal Parliament (often referred to as the Australian or Commonwealth Government), which makes laws for the whole country.

2. Six state and two mainland territory parliaments, which produce legislation that applies only to their state or territory.
3. Around 560 local councils, which make local laws – bylaws – for the region or district that they control.

Each government has its own responsibilities, although they sometimes overlap with each other. This report focuses primarily on policies and programmes developed and funded by the federal government (or Commonwealth Government), even though responsibility for implementation often lies with a mixture of federal and state and territory government agencies.

Promoting and implementing policy reforms of national significance or co-ordinated action across all levels of governments is the task of the Council of Australian Governments (COAG), the country's supreme intergovernmental forum. Members of COAG are the Prime Minister, state and territory premiers and chief ministers, and the President of the Australian Local Government Association. Formal agreements on policy directions, implementation arrangements, funding, evaluation or reporting (or any combination thereof) are formalised in intergovernmental agreements known as National Agreements and National Partnership Agreements.

In response to criticism from community stakeholders at the slow roll-out of the mental health reform agenda, COAG endorsed and published the Ten Year Roadmap for National Mental Health Reform (sometimes referred to as the "Roadmap") in 2012. The Roadmap states that mental health reform must cross sectors and service settings – including that employment services need to address mental health issues. In an additional move, the government set up an independent National Mental Health Commission in 2012. It operates across all jurisdictions and sectors, advising and collaborating with other stakeholders to help promote change to ensure mental health and wellbeing. The Commission reports to COAG and the community at large on the progress of the Roadmap through its annually published National Report Card on Mental Health and Suicide Prevention.

While many government agencies are engaged in the provision of services to people with mental illness, public policy approaches too often focus on measuring outputs, such as treatment rates (in the health system) and competitive tendering (in the employment services system). That approach leaves Australia largely outcome-blind with regard to the health, economic and social impact of mental health care and employment services, and generates competition, rather than collaboration, between service providers.

Trends and outcomes: Where Australia stands

Despite the well-advanced thinking behind work and mental health policy, Australia's actual social and labour market outcomes are no better than in other OECD countries and, in some respects, even worse.

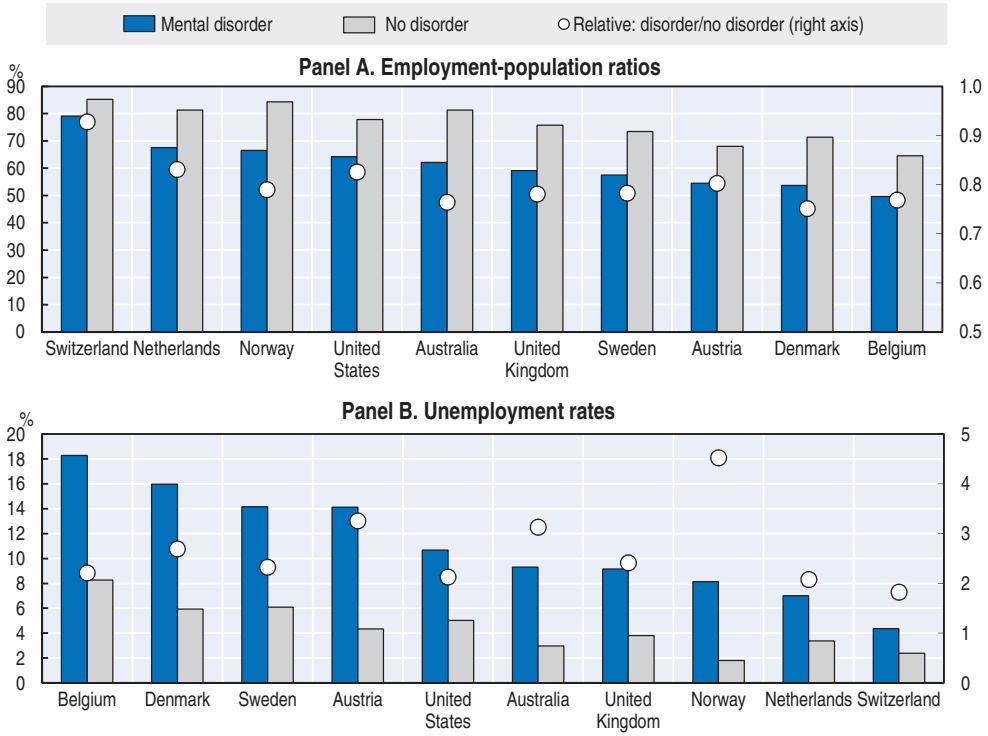
The global financial crisis has affected Australia considerably less than many other countries. When it struck in 2008, Australia was in very robust financial health. It was debt-free, boasted strong growth with significant assets, and was running budget surpluses. Along with highly favourable terms of trade, Australia weathered the crisis in much better shape than most other developed economies, many of which experienced severe recessions and sharp rises in unemployment. In 2014, the employment rate of 15 to 64 year-olds in Australia stood at 71.6%, compared with the OECD average of 65.8%, and unemployment was 6.2%, lower than the OECD-wide average figure of 7.5% (OECD, 2015b).

However, despite the more favourable economic conditions, the employment rate among people with a mental disorder is 62.2% – in line the average of the 10 OECD countries for which comparable data are available (Figure 1.2, Panel A). As a result, the employment gap between people with and without mental health problems is the second highest of the 10 countries considered, just behind Denmark. The same may be said of unemployment among workers with a mental disorder in Australia. Although the rate is on a par with the 10-country average, the gap in Australia between people with mental health complaints and those with none is again among the widest: those with complaints are more than three times as likely to be unemployed than their mentally healthy peers (Figure 1.2, Panel B).

Because people with mental health problems perform so poorly on the labour market, they are a major challenge to Australia's different income support systems. About 26% of people with a severe mental disorder receive a disability benefit, but an even higher share (31%) relies on unemployment, lone-parent, or other allowances (Figure 1.3). Even among people who suffer from a moderate disorder, 40% depend on an income replacement benefit.

Like many other OECD countries, Australia has seen disability benefit claim rates rise steadily over recent decades. In 2013, 5.5% of the population aged 20-64 was in receipt of a disability benefit, up from 4.2% in the mid-1990s (Figure 1.4, Panel A), and in line with the OECD average. Although the continued growth in the number of disability benefit recipients is a major concern among policy makers, McVicar and Wilkins (2013) have demonstrated that, since the late 1990s, it can be wholly attributed to population growth, ageing, and women's later retirement age.

Figure 1.2. **The labour market outcomes of people with mental disorders in Australia are in line with OECD averages, but the gap with their healthy peers is amongst the widest**

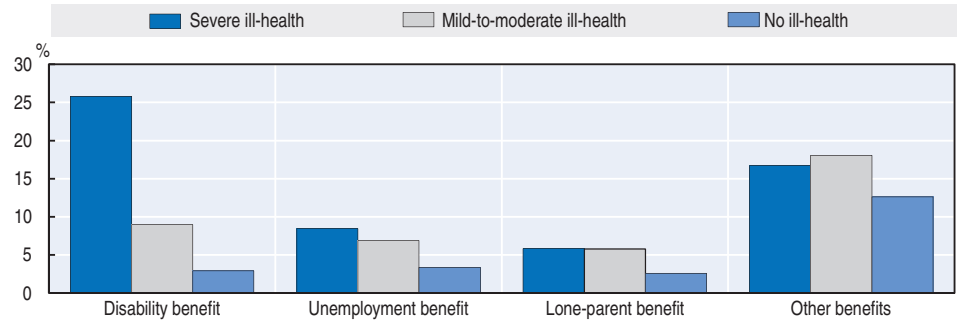


Source: OECD calculations based on national health surveys. Australia: ABS National Health Survey 2011-12; Austria: Health Interview Survey 2006-07; Belgium: Health Interview Survey 2008; Denmark: National Health Interview Survey 2010; Netherlands: POLS Health Survey 2007-09; Norway: Level of Living and Health Survey 2008; Sweden: Survey on Living Conditions 2009-10; Switzerland: Health Survey 2012; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: National Health Interview Survey 2008.

StatLink http://dx.doi.org/10.1787/888933287442

Figure 1.3. **People who suffer from mental health problems are more likely to receive a benefit**

Benefit recipiency rate in per cent by type of benefit and mental health status



Note: Other income-replacement benefits are Carer Payment, Partner Allowance, Widow Allowance, Sickness Allowance, Austudy, ABSTUDY and Special Benefit.

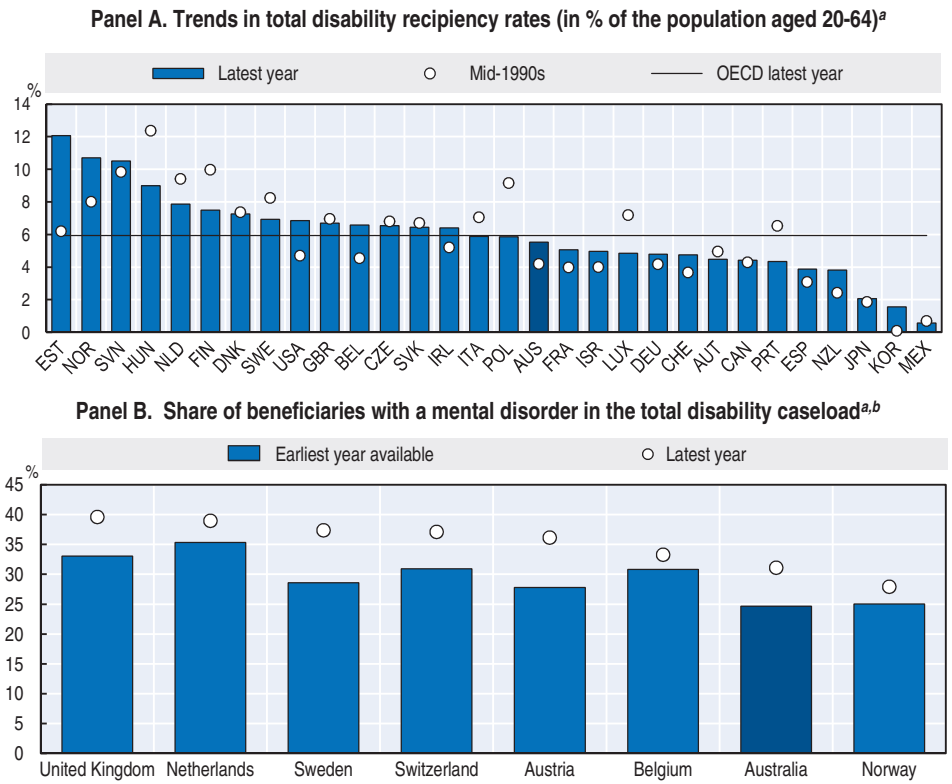
Source: OECD calculations based on ABS National Health Survey 2011-12.

StatLink http://dx.doi.org/10.1787/888933287450

The share of beneficiaries with a mental disorder in the total disability caseload has risen also in Australia, as in many other OECD countries. By 2013, the primary condition of 31% of all disability benefit claimants was mental ill-health – up from 25% ten years earlier (Figure 1.4, Panel B). As discussed in Chapter 5, greater awareness of mental ill-health accounts for part of the increase.

The weak labour market integration of people with mental ill-health, together with their low benefit payments and coverage (Chapter 5) translate into higher income poverty rates than among their mentally healthy peers. With estimated rates of 36%, people with severe mental disorders in Australia are more likely to be living in poverty than in many of the other OECD countries for which data are available (Figure 1.5). As for the poverty risk among people who suffer from mild-to-moderate mental disorders, it is around average for the OECD countries where comparable data are available.

Figure 1.4. **Both the disability recipiency rate and the share of mental disorders have increased in recent decades**



a. Norway includes the temporary benefit in Panel A, but not in Panel B.

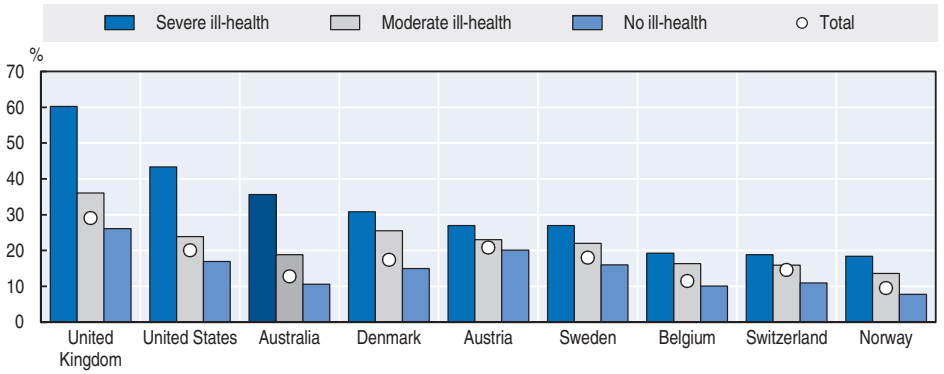
b. Data for Austria, Belgium, the Netherlands and Sweden include mental retardation and organic and unspecified disorders.

Source: OECD calculations based on the OECD Disability Questionnaire and the OECD Mental Health Questionnaire.

StatLink http://dx.doi.org/ 10.1787/888933287464

Figure 1.5. **The risk of poverty is high among people who suffer from mental ill-health**

People in low-income households by mental health status, latest year available



Note: Per-person net income adjusted for household size. For Australia, Denmark and the United Kingdom data refer to gross income. Net-income based data from the 2006 Health Survey for England (HSE) confirm the high poverty risk, even higher than in the United States. The low-income threshold for determining the risk of poverty is 60% of median income.

Source: National health surveys. Australia: National Health Survey 2011-12; Austria: Health Interview Survey 2006-07; Belgium: Health Interview Survey 2008; Denmark: National Health Interview Survey 2005; Netherlands: POLS Health Survey 2007-09; Norway: Level of Living and Health Survey 2008; Sweden: Living Conditions Survey 2009-10; Switzerland: Health Survey 2012; United Kingdom: Adult Psychiatric Morbidity Survey 2007; United States: National Health Interview Survey 2008.

StatLink http://dx.doi.org/10.1787/888933287478

Round-up

The key facts to emerge from this brief round-up of Australian policy on work and mental health and the challenges it faces are:

- Despite well-advanced policy thinking on mental health and work, the social and labour market outcomes of people with mental health problems in Australia are no better than in other OECD countries and, in some respects, even worse.
- People with mental health problems do not benefit from Australia's generally robust labour market. The gaps between the employment and unemployment rates of people with mental health problems and their mentally healthy peers are amongst the highest of the OECD countries for which data are available.
- The disability benefit caseload has steadily swollen over time, reaching the OECD average in 2013. As in many other OECD countries, poor

mental health accounts for an increasingly significant share of the disability caseload.

- Mental ill-health exacts a heavy toll on well-being in Australia, with poverty rates among people with a severe mental disorder that are higher than in many other OECD countries.

Notes

1. Intellectual disabilities, such as mental retardation and learning disabilities, organic mental illnesses, and problems that develop later in life through brain injury or neurodegenerative diseases like dementia are not included in the calculations as they are outside the scope of this report.
2. The prime concern of the report is the mutual interplay between work and poor mental health. It uses a number of interchangeable terms that are general in scope to denote poor mental health – e.g. "mental ill-health", "mental disorder", "mental illness", "mental health problem" or "condition". It specifies, where necessary, whether a condition is serious or mild-to-moderate. Most sufferers grapple with the mild-to-moderate kinds of mental ill health, which can be quite enough to affect their performance in the workplace, their employment prospects and, more widely, their place in the labour market.

References

Gustavsson, A. et al. (2011), "Cost of Disorders of the Brain in Europe 2010", *European Neuropsychopharmacology,* Vol. 21, pp. 718-779.

McVicar, D. and R. Wilkins (2013), "Policy Forum: Disability Care and Support. Explaining the Growth in the Number of Recipients of the Disability support Pension in Australia", *Australian Economic Review*, Vol. 46, No. 3, pp. 345-356.

Medibank and Nous Group (2013), *The Case for Mental Health Reform in Australia: A Review of Expenditure and System Design*, Medibank and Nous Group.

OECD (2015a), *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264228283-en.

OECD (2015b), *OECD Employment Outlook 2015*, OECD Publishing, Paris, http://dx.doi.org/10.1787/empl_outlook-2015-en.

OECD (2012), *Sick on the job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris. http://dx.doi.org/10.1787/9789264124523-en.

Chapter 2

Mental health services and the integration of employment support in Australia

This chapter discusses Australia's mental health policy and assesses the effectiveness of the mental health system in providing the right treatment to people with mild-to-moderate mental disorders. Subsequently, it discusses the role of general practitioners and the accessibility of specialist mental health care. Finally, it reviews measures to integrate employment and mental health services.

Effective treatment is essential if mental disorders are not to become chronic, turn into permanent disability, and result in the incapacity to work. The availability and accessibility of mental health services is a challenge in large countries like Australia with many remote areas. The separate responsibilities of the federal government and the states and territories for, respectively, primary and specialised care impede continuity of care and heighten the risk of inadequate or wrong treatment. Additionally, a growing body of scientific evidence suggests that psychological treatment in itself does not improve work outcomes, but that work-focused interventions are necessary (Ejeby et al., 2014). Building structures that integrate mental health and employment support services is crucial. This chapter addresses those challenges.

Mental health policy reform and the treatment gap

Australia has developed a strong mental health policy agenda

Over the past two decades, improving the mental health system has been high on Australia's policy agenda. Until 1992, mental health legislation was solely the responsibility of the individual states and territories. Since then, however, the Commonwealth Government has assumed its share with the development of the National Mental Health Strategy. It has also introduced other policy reforms to improve mental health care (Box 2.1).

Nevertheless, the Australian mental health care system is still fragmented. While the Commonwealth Government manages and funds general practitioners (GPs) and primary health care services, public hospital care is the job of the states and territories (with some federal funding). The two tiers of government share responsibility for community care services, with states and territories shouldering the bulk of those that specialise in mental health. Other players in the field are the many mental health non-governmental organisations (NGOs) and private psychiatric hospitals (COAG, 2011; Medibank and Nous Group, 2013).

The multifaceted nature of mental health problems, often associated with social problems and comorbidity, means that many patients need multiple health care services and wider-ranging social support. However, the fragmented mental health system is an obstacle (OECD, 2012). Australian policy initiatives of the past two decades have not addressed the system's design. They have merely taken their place in a fragmented, unco-ordinated system, leaving patients to find their way through unclear care pathways (Medibank and Nous Group, 2013).

Box 2.1. **Policy initiatives to improve mental health care**

The National Mental Health Strategy rolled out in 1992 with the backing of all governments and sought to improve the lives of people with mental disorders. It was followed by series of further policy measures (Department of Health and Ageing, 2013a; COAG, 2012; OECD, forthcoming).

- The **National Mental Health Policy** sets directions for the development of mental health services across Australia;
- The **mental health statement of rights and responsibilities** describes the rights and responsibilities of consumers, carers, advocates, service providers, and the community regarding mental health needs and care;
- The **Australian health care agreements** are five-year bilateral agreements between the Commonwealth and each state and territory. They include agreements on Commonwealth funding of mental health care;
- The **National Mental Health Plans** determine priorities for mental health care and monitor the development of mental health services and policies. Four plans covering five-year periods have been drawn up so far, with the latest covering the period 2009 to 2014. Where the first plan (1993-98) was concerned primarily with de-institutionalisation and severe disorders, the ensuing ones focused on prevention, health promotion, de-stigmatisation and mild disorders. The fourth plan also addresses interaction with other policy areas and the importance of a whole-of-government approach.
- The **National Disability Insurance Scheme** provides support to people with permanent and significant disability and their families and carers. The scheme was launched in 2013 and is being implemented in stages with full roll out commencing progressively from July 2016. The scheme will provide a holistic approach that responds and addresses the many barriers people with disability face in social and economic participation. As such, it will also be relevant for some of those with a mental disorder.

The Council of Australian Governments (COAG) further complemented those measures and schemes with the National Action Plan on Mental Health 2006-11. COAG intended it as a strategic framework for collaboration between government and non-government health care providers. With it came extra funding.

More recently, COAG introduced the Ten Year Roadmap for National Mental Health Reform 2012-22. The Roadmap outlines six priority areas along with the implementation strategies that the different tiers of government should follow. It specifies that mental health reform must cross sectors and service settings – including that employment services should address mental health issues. The goal is better targeting of the mental health care budgets that reform has increased.

The question thus arises as to whether reform has helped improve mental health care, or whether it has only added to complexity. Important performance indicators are treatment rates, unmet needs for care and availability of care (adequate staffing levels), timeliness (no or short waiting lists), and the appropriateness of treatment (type and patient satisfaction) of services (OECD, 2012). However, the fragmented system hampers the collection of data for those indicators. As a result, there is no single average statistic which could sum up the performance of the Commonwealth's and states' and territories' mental health services (Department of Health and Ageing, 2010a). That constraint should be borne in mind when considering the data on performance of the mental health system presented in the following sections (i.e. data mostly pertain to the Commonwealth level and do not include state and territory services).

A treatment gap remains between those suffering from mental health problems and those receiving support

Because multi-tier management keeps the government datasets separate, they can paint only a partial picture of the mental health care system. Large-scale population surveys can provide a more comprehensive view, however. The National Survey of Mental Health and Wellbeing (NSMHWB), for example, conducted in 1997 and 2007 by the Australian Bureau of Statistics, put questions to respondents who had suffered from a mental disorder in the previous 12 months, assessed through the World Health Organization's World Mental Health Composite International Diagnostic Interview (WHO WMH-CIDI). The questions related to their use of mental health services over the past 12 months, which included any community-based service, mental health hospitalisation, and any consultation with a general practitioner, psychiatrist, psychologist, mental health professional, or other health professional (Burgess et al., 2009).

The NSMHWB shows that there is a wide treatment gap between those suffering from mental health problems and those receiving support. Even though there was a slight increase in the treatment rate from 32.5% to 34.9% between 1997 and 2007, only about one-third of all those who had suffered from a disorder in the last 12 months received treatment (Burgess et al*., 2009*). The rate was especially low among those with mild-to-moderate complaints, with only 11.4% of people with mild complaints and 27.9% of people with moderate complaints having consulted a GP. By contrast, the figure was 49.7% among people with severe problems (Burgess et al., 2009). While it is reasonable to expect that people with more severe problems receive more care, getting none at all can lead to deterioration among people with mild or moderate conditions.

To address low treatment rates among people with mild-to-moderate mental disorders, the Commonwealth Government introduced two new programmes – Access to Allied Psychological Services (ATAPS) in 2003 and Better Access to Psychiatrists, Psychologists and General Practitioners (Better Access) in 2006 (Box 2.2).

Box 2.2. **The ATAPS and Better Access initiatives**

The Access to Allied Psychological Services (ATAPS) initiative funds the provision of short-term psychological services through fundholding arrangements. It enables GPs to refer patients with high-prevalence mental disorders for six sessions of evidence-based mental health care to allied health professionals (i.e. psychologists, social workers, mental health nurses, occupational therapists, and Aboriginal and Torres Strait Islander health workers with specific mental health qualifications). After the six sessions, the GP may decide to refer a patient for an additional six if the allied health professional's report deems it necessary. In exceptional circumstances (e.g. a significant change in the patient's clinical condition or care circumstances), there can be up to 18 sessions per calendar year.

The Better Access to Psychiatrists, Psychologists and General Practitioners (Better Access) is an initiative introduced to make rebates available for certain mental health services under the Medicare Benefit Scheme (Australia's publicly funded universal health care system). The services can be provided by GPs or psychiatrists or allied health care professionals like psychologists, social workers and occupational therapists. Services that are rebated are, for example, GP mental health consultations, the preparation of a GP mental health care plan and psychological therapies provided by a clinical psychologist.

There are three main differences between ATAPS and Better Access (Department of Health and Ageing, 2010b; Pirkis et al., 2011).

First, ATAPS is financed through fundholding arrangements (i.e. a finite budget) used to salary or subcontract allied health professionals while Better Access is funded through the Medicare Benefit Schedule.

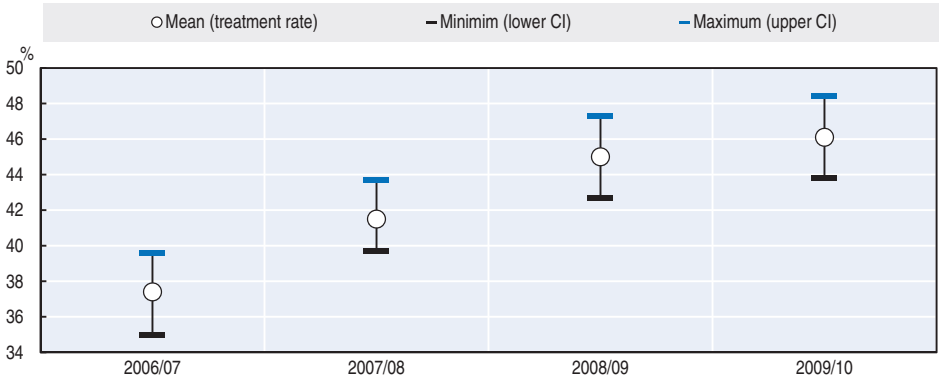
Second, ATAPS offers more flexibility at the local level to retain the necessary allied health professionals while Better Access provides greater access to services thanks to its significantly larger programme budget.

Third, ATAPS offers a broader range of service providers than Better Access. It includes mental health nurses and Aboriginal and Torres Strait Islander health workers

In 2011, Pirkis et al. evaluated whether the mental health treatment rate had increased since the introduction of ATAPS and Better Access. Because no single database contains such information, the Department of Health and Ageing estimated the change in treatment rates between 2006-07 and 2009-10 on the basis of routinely available data from the Commonwealth and states and territories. Figure 2.1 shows the estimated mean treatment rates between those years with 95% confidence intervals.

Figure 2.1. **Treatment rate of people with mental disorders have slightly risen**

Estimated share of people with a mental health problem who received treatment, 2006-10



CI: Confidence interval.

Source: Pirkis, J., M. Harris, W. Hall and M. Ftanou (2011), "Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summary Evaluation", University of Melbourne, Melbourne.

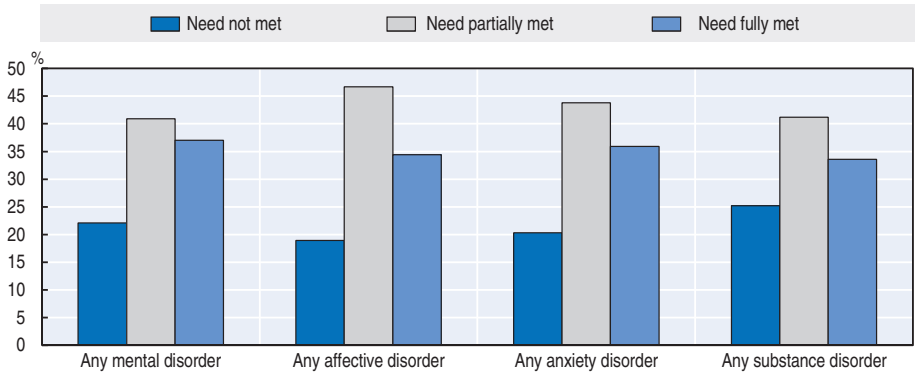
StatLink http://dx.doi.org/10.1787/888933287486

Figure 2.1 suggests that the estimated mean treatment rate increased from 37.4% in 2006-07 to 46.1% in 2009-10. However, the 95% confidence intervals point to considerable uncertainty over those estimates. Because the confidence intervals for the years 2007-08, 2008-09, and 2009-10 show extensive overlap, the rise in treatment rate between these years could well be due to chance variations in the data.

The share of people with mental ill-health who experience an unmet need for treatment is also an important indicator of a possible treatment gap. Not everyone who receives no treatment experiences the need for it, while some people who do get treatment feel that it does not meet all their needs. The 2007 NSMHWB also assessed the unmet need for treatment among people with 12-month mental disorders. Of those who perceived a need for some form of treatment, 22.1% experienced an unmet need, while 40.9% felt that their need had been only partially met (Figure 2.2). People with a 12-month substance use disorder reported the highest rates of unmet needs (Meadows and Burgess, 2009).

Figure 2.2. **A substantial proportion of people with mental disorders experience an unmet need for treatment**

Share of people reporting an unmet need for treatment, by type of disorder, 2007



Source: Meadows, G. and P. Burgess (2009), "Perceived Need for Mental Health Care: Findings from the 2007 Australian Survey of Mental Health and Wellbeing", *Australian and New Zealand Journal of Psychiatry*, Vol. 43, pp. 624-634.

StatLink http://dx.doi.org/10.1787/888933287495

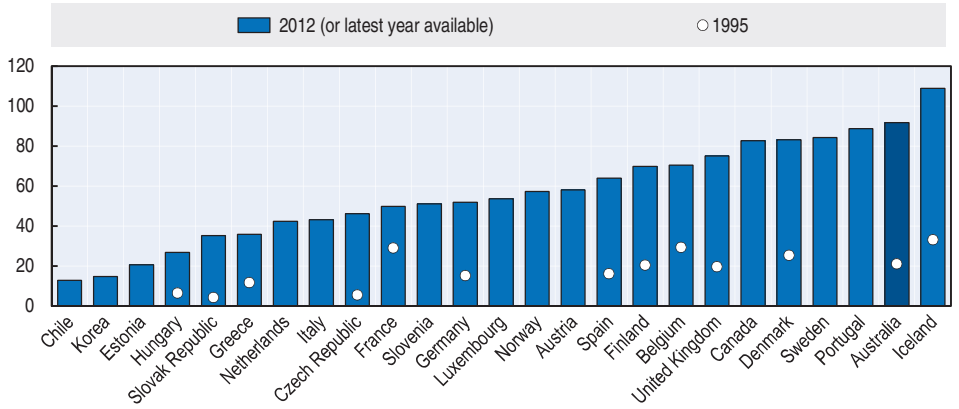
Type of treatment provided

Higher treatment rates help improve mental health outcomes, but only if the treatment is the right one. Many studies have shown that cognitive behavioural therapy (CBT) can be particularly effective (Butler et al., 2005). Indeed, when it comes to mild and moderate conditions, psychotherapy might well be more appropriate than antidepressants, as their effectiveness increases with the severity of the illness (OECD, 2012). A number of studies have shown that CBT is actually more effective than antidepressants in reducing depressive symptoms in adults with unipolar depression (Butler et al., 2005).

Despite the scientific evidence that advocates psychotherapy, data presented below show that psychotropic medication is more widely used in Australia to treat mental ill-health. Indeed, the country's antidepressant consumption is one of the highest in the OECD and rose steeply between 1995 and 2012 (Figure 2.3).

Figure 2.3. **Consumption of antidepressants is very high in Australia and has grown considerably**

Defined daily dosage per 1 000 inhabitants, 2012



Note: Data for 1995 refer to 1996 for the Slovak Republic, 1997 for Belgium and Denmark and 1998 for Greece.

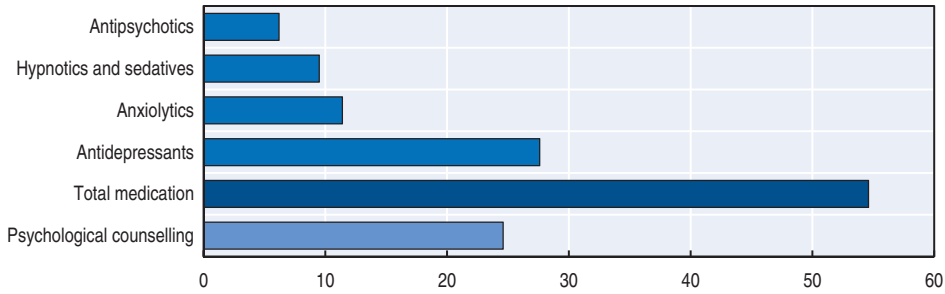
Source: *OECD Health Database*, Pharmaceutical Market dataset.

StatLink http://dx.doi.org/10.1787/ 888933287505

A survey conducted in 2011-12, Bettering the Evaluation and Care of Health (BEACH), which evaluates general practice activity, revealed that GPs are more likely to provide medication than counselling (Figure 2.4). A similar picture emerges from comparisons of all subsidised mental-health-related services with prescriptions for medication. In 2011-12, some 1.6 million people received some form of subsidised mental health counselling and psychotherapy, while about 2.5 million were prescribed medication like antipsychotic drugs and antidepressants (Australian Institute of Health and Welfare, 2014).[1]

Figure 2.4. **GPs use psychotropic medication more widely than psychological counselling**

Types of mental illness management used by GPs per 100 mental health complaints managed, 2011-12



Source: OECD compilation based on data from the Australian Institute of Health and Welfare (http://mhsa.aihw.gov.au/home/, accessed 2 September 2015).

StatLink http://dx.doi.org/10.1787/888933287519

Primary health care and specialist services for mental health problems

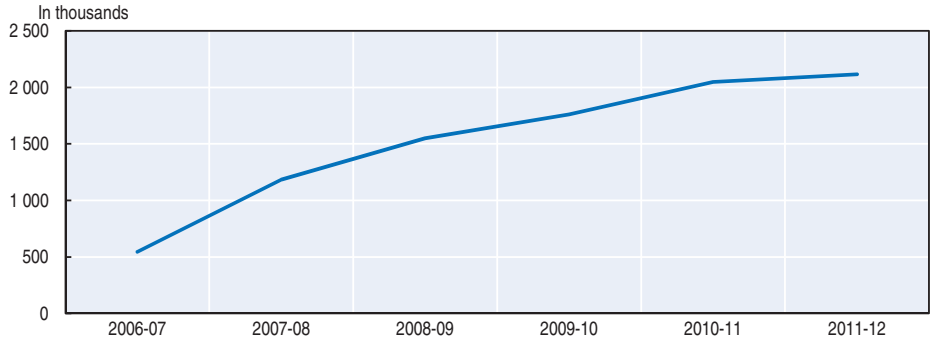
General practitioners are the primary providers of mental health care

As in many other OECD countries, the general practitioner (GP) is the gatekeeper to the mental health care system. To receive government-subsidised mental health treatment from specialists such as psychologists and psychiatrists, patients must be referred by their GP.

GPs are among the main providers of mental health treatment, especially for patients with mild and moderate disorders. In recent years, mental health treatment by GPs has increased steadily (Figure 2.5). The increase is most likely due to the introduction of the Better Access initiative in 2006, which made GP mental health services rebatable under the Medicare Benefit Schedule (MBS). Although services by allied health professionals are also MBS-rebated under Better Access, the increase in their use has been much less pronounced (Figure 2.6).

Figure 2.5. **Sharp increase in GPs' treatment[a] of mental ill-health**

Number of Medicare-subsidised GP mental health-related services,[b] 2006-12



a. GP mental health-related services can be either preparation of a GP mental health treatment plan, a review of a GP mental health treatment plan, or a GP mental health consultation defined as a professional attendance that includes taking relevant history, identifying problems, providing treatment, advice and/or referral and lasts at least 20 minutes.

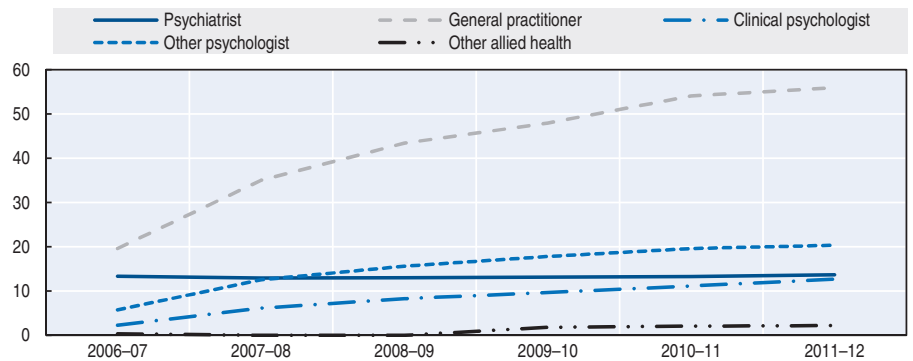
b. The number of services is not equal to the number of people treated, as patients may receive more than one type of service or similar services more than once.

Source: OECD compilation based on data from the Australian Institute of Health and Welfare, http://mhsa.aihw.gov.au/home/, accessed 2 September 2015).

StatLink http://dx.doi.org/10.1787/888933287522

Figure 2.6. **The increase in the use of mental health services by allied professional providers is lower than the use of GP provided services**

People receiving Medicare-rebated mental health services, per 1 000 people, by type of provider, 2006-12



Source: OECD compilation based on data from the Australian Institute of Health and Welfare (2014) http://mhsa.aihw.gov.au/home/ (accessed 2 September 2015).

StatLink http://dx.doi.org/10.1787/888933287533

Since Better Access made GP-provided mental health services rebatable, mental health training for physicians has become an important issue for the Commonwealth Government. Accordingly, the Department of Health funds the General Practice Mental Health Standards Collaboration (GPMHSC), the multidisciplinary body that sets standards of GP education and training in mental health. The GPMHSC offers four types of accredited training through which GPs can acquire competencies and continue their professional development (Box 2.3).

GPs have a financial incentive to gain accreditation in Mental Health Skills Training (MHST), as it entitles them to claim higher fees for the MBS-rebated mental health services that they provide.

GPs who have gained their MHST credentials may further enhance their mental health skills through training in Focussed Psychological Strategies (FPS) – specific mental health treatment strategies derived from evidence-based psychological therapies. Successful completion of an FPS skills training course entitles GPs to register with the GPMHSC as a FPS provider and offer MBS-rebated FPS services for which fees are higher than normal GP mental health consultations (General Practice Mental Health Standards Collaboration, 2013). Anecdotally, about 80% of the GPs have completed the Mental Health Skills Training.

The 2011-12 BEACH survey showed that GPs most frequently have to contend with depression (34% of all mental health problems), followed by anxiety (15%), and sleep disorders (12%). They more seldom manage more severe conditions such as schizophrenia and affective psychosis, which respectively account for 4% and 2% of all mental health problems (AIHW, 2014).

GPs can request support for treating people with severe mental disorders through the Mental Health Nurse Incentive Program (MHNIP), which funds general practices so that mental health nurses can be employed. Nurses offer services such as monitoring a patient's mental state, medication management, and improving links with other health care professionals and clinical service providers. They provide their services in settings that range from clinics to patients' homes at little or no cost to the patient.

An evaluation of the MHNIP found that it led to greater continuity of care, more effective follow-up, timely access to support, and increased compliance with treatment plans. It also appears to have improved rates of employment and activity among patients.

Box 2.3. **GP mental health training in Australia**

The General Practice Mental Health Standards Collaboration, the multidisciplinary body that sets standards and content of GP education and training, offers GPs accredited training schemes in basic mental health skills and specific, "focused" therapies.

Accreditation category	General objectives	Minimum duration	Activity format
Mental Health Skills Training (MHST)	Provide training in mental health assessment, treatment planning and review of mental illnesses that commonly present in general practice	6 or 7 hours	Any interactive, structured learning format with pre-disposing and reinforcing elements
Focussed Psychological Strategies Skills Training (FPS ST)	Develop skills in provision of evidence-based FPS as part of a treatment plan for common mental illnesses. To train in FPS, GPs must first successfully complete MHST.	20 hours	At least 12 hours of supervised face-to-face training, with the balance via any interactive, structured learning format, plus an additional 8-hour active learning module. Also requires predisposing and reinforcing elements
Mental Health Continued Professional Development	Extend MHST, augmenting skills in assessing and treating mental health issues	Varies depending on the activity	Includes, active learning module, clinical audit, research activity, small group learning and supervised clinical attachments
Focussed Psychological Strategies Continued Professional Development	Extend FPS ST and strengthen skills in the provision of FPS		

Source: The General Practice Mental Health Standards Collaboration (2013), http://www.racgp.org.au/education/gpmhsc.

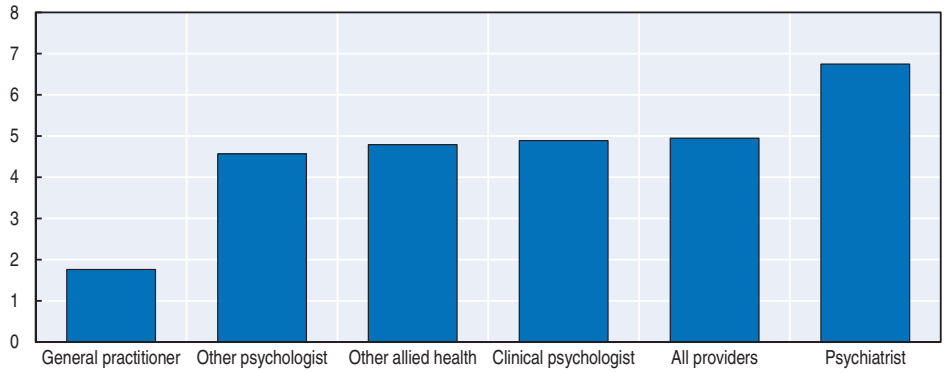
Of 72 clients who were surveyed about MHNIP, 19% reported they had found full- or part-time jobs, 13% had gone into voluntary work, and 7% had started or returned to study. Reduced hospital admissions yielded savings that were equivalent to MHNIP's average direct subsidy levels. The

evaluation also showed that demand for nurses has outstripped supply. Of 47 medical practitioners questioned about how to cope with patient demand for MHNIP, the most frequently mentioned strategies were waiting lists (47%) and triage (28%) (Department of Health and Ageing, 2012a).

Few people receive specialised care

Only a minority of the people with a mental health problem benefit from specialised care. Data from the 2011-12 BEACH survey show that GPs referred few patients with mental health problems to allied mental health specialists: they referred 7% to psychologists and 2% to psychiatrists. While not all people with mental health problems need specialist treatment, these rates are low compared to data available for European countries where, on average, 15% receive treatment from a psychiatrist or psychologist (OECD, 2014). ATAPS and Better Access appear to have increased mental health treatment provided by GPs, but not by specialised professionals. GPs themselves account for approximately 78% of the provision of MBS-rebated mental health services (Figure 2.7). What makes the finding disconcerting is that the mean number of mental health services per patient that GPs offer is low – less than two per year.

Figure 2.7. **Number of mental health services per patient rebated by the Medicare Benefit Scheme, by provider, 2011-12**



Source: OECD compilation based on data from the Australian Institute of Health and Welfare (2014) http://mhsa.aihw.gov.au/home/, accessed 2 September 2015).

StatLink http://dx.doi.org/10.1787/888933287544

People with mental health problems may also receive specialised care in private hospitals, state and territory public hospitals, and community settings. In-hospital treatment has declined since the 1990s as a result of policy measures to deinstitutionalise mental health care, and has stabilised at

around six admissions per 1 000 population in public and private hospitals combined since 2006 (AIHW, 2014).

Deinstitutionalisation has prompted a rise in community mental health care services. The number of services grew from 217 per 1 000 population in 2001-2 to 333 in 2011-12. In contrast, there were 98 services per 1 000 people for MBS-rebated, GP-provided mental health care in 2011-12 (AIHW, 2014). This difference is attributable partly to the fact that, although fewer people receive community care – 300 000 in 2011-12 – they use such services more often than patients who turn to MBS-rebated GP services, who numbered 1.25 million. In other words, a growing group receives specialised community mental health care, although this is still a relatively small group compared to those who receive MBS-rebated, GP-provided mental health care.

Community mental health care is well suited to mild-to-moderate mental health problems. "Depressive episodes" and "reactions to severe stress and adjustment disorders" belong to the five most commonly reported diagnoses of people treated in community services. They also accounted for the longest service durations.

The split between Commonwealth and state-and-territory responsibilities

Multiple problems spring from the fragmented mental health system in which the Commonwealth Government is responsible for primary care and the states and territories for specialist services. Important issues are the lack of clarity over responsibilities, poor continuity and co-ordination of care, cost-shifting, and the duplication of services. As a result, the different tiers of governments have perverse financial incentives to redirect patients to either primary care or specialised services (which includes community care). Furthermore, health care providers in one system have no incentive to ensure the smooth transfer of patients to another one, which impairs continuity of care (OECD, forthcoming; Dwyer and Eager, 2008).

Medicare Locals, a failed attempt to co-ordinate health care

In recognition of the problems due to the fragmented system, the Commonwealth Government moved to step up its management and funding of all GP-provided and primary health care. Accordingly, in 2012 it restructured primary health care. It replaced Divisions of General Practice – regionally-based, government-funded associations of general practitioners which co-ordinated local primary care services – with locally based primary health care organisations called Medicare Locals. Medicare Locals, which were largely modelled on the Divisions of General Practice, had a broad mandate to:

- Improve the patient's journey through different health services (i.e. the clinical pathway) by developing integrated, co-ordinated services;
- Support clinicians and service providers;
- Identify the health needs of local areas and develop services that respond to them;
- Facilitate the implementation of primary health care programmes.

Furthermore, in order to integrate services, Medicare Locals worked with Local Hospital Networks (LHNs) – the organisations that manage public hospitals grouped into local networks (COAG, 2011). However, the infrastructure in place was inadequate to the task of collaborating with other health care organisations and co-ordinating care. The effect on people with mental ill-health was undoubtedly detrimental, as they are often confronted with multiple problems (both health-related and social in nature) and disorders that are chronic or recurrent and need constant, co-ordinated primary and specialist care.

A review of Medicare Locals in 2014 by former Australian Government Chief Medical Officer, Professor John Horvath, found that they suffered from a lack of clarity as to what they were supposed to achieve. As a result, they pursued a great variety of activities, creating confusion among service providers and patients about their purpose (Horvath, 2014). Horvath concluded that the Medicare Locals did not have the leverage to negotiate with LHNs, thus further impeding the development of collaborative clinical pathways. Indeed, patients continued to report that they experience fragmented care. Horvath also observed that little was known on relevant outcomes (e.g. patient follow-up and treatment waiting times), which hampered the performance assessment of the Medicare Locals in establishing care pathways and improving patient outcomes.

Horvath recommended replacing Medicare Locals by Primary Health Organisations (PHOs). Their prime role would be to establish clinical pathways of care through collaboration with GPs, private specialists, LHNs, private hospitals, and other care providers. To ensure that PHOs enjoy enough leverage to negotiate with other providers, they need to cover larger regions than the Medicare Locals and have funding that is more flexible than programme funding. Horvath stressed that a set of performance indicators with a focus on measurable outcomes would be required to assess PHOs' effectiveness. In line with his recommendations, the Commonwealth Government has replaced Medicare Locals by Primary Health Networks (PHNs) as of July 2015. The Department of Health is still drawing up policy for the new PHNs.

Internet- and telephone-based mental health services

A major challenge for health care delivery in Australia is reaching people living in remote areas. The provision of MBS-rebated mental health services is substantially lower in remote areas than in cities and inner regional areas (Figure 2.8).[2] A slight increase in services has nevertheless been observed since 2006 – possibly prompted by ATAPS's change of focus in the wake of the introduction of the Better Access Initiative in 2006. As Better Access brought Medicare-rebated mental health services to a broader population, ATAPS concentrated more on service gaps and groups who were not well served by Better Access or other mental health programs. ATAPS now consists of two tiers (Department of Health and Ageing, 2012b):

1. Funding for Medicare Locals until July 2015 and from then on for Primary Health Networks so that they may provide psychological services to hard-to-reach groups in their region as a complement to Medicare-rebated care;

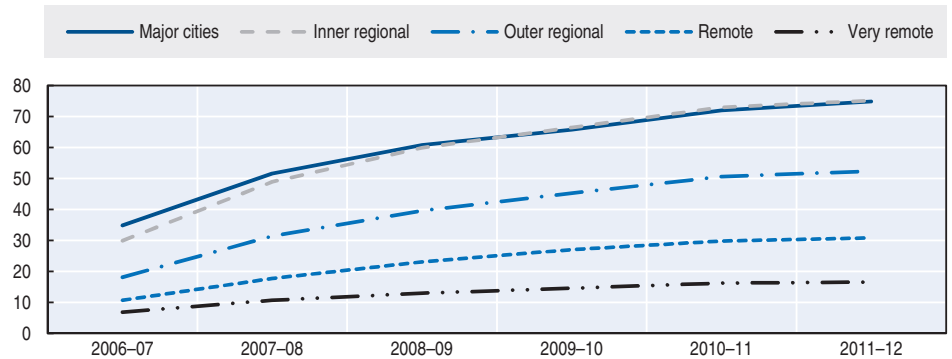
2. Flexible, special-purpose funding for innovative service delivery to high-priority groups that Tier 1 does not reach (which includes people in remote areas).

Internet- and telephone-based mental health services could be part of a solution for reaching people in remote areas. There are several schemes available, such as video-conferencing and telephone-based cognitive behavioural therapy, for which ATAPS funding can be requested. Web-based therapies are freely accessible without referral, too. Examples are the e-therapy programmes for anxiety disorders from the National eTherapy Unit at the Swinburne University of Technology and the MoodGYM programme for depression and anxiety from the Centre for Mental Health Research at the Australian National University (Department of Health and Ageing, 2012b). Furthermore, the Australian Government, in collaboration with five other institutions, recently launched the "E-mental health in practice" initiative, which aims to increase engagement of health professionals in the use of e-mental health. [3]

To date, however, only limited use has been made of video-conferencing and telephone- and web-based therapy under ATAPS. A 10-year evaluation report showed that only 0.7% of all services were delivered by telephone and an even smaller percentage through video-conferencing and the Internet. Despite such low figures, however, there has been a clear rise in the use of such treatment since 2007-8 (Bassilios et al., 2013).

Figure 2.8. **People in remote areas are four times less likely to receive mental health care**

Number of people per 1 000 population receiving rebated mental health care by remoteness of area, 2006-12



Source: OECD compilation based on data from the Australian Institute of Health and Welfare http://mhsa.aihw.gov.au/home/, accessed 2 September 2015).

StatLink http://dx.doi.org/10.1787/888933287557

One drawback of web-based therapies is that they are often self-help programmes with no intervention from a treatment provider. Yet research has shown that results are better if there is some form of feedback, whether by phone or email (Spek et al. 2007). Also problematic is that web-based therapies have high drop-out rates (Christensen, Griffiths and Farrer, 2009; Melville, Casey and Kavanagh, 2010; van Ballegooijen et al., 2014). Intervention from a carer could help contain drop-out.

Employment services in mental health care

A focus on employment in the treatment of mental health problems is paramount. People with mental health problems frequently have to contend with multiple additional problems; this often includes staying in, returning to, or finding work. Moreover, work is often an important element of recovery and rehabilitation, and one that should not and cannot be overlooked.

Like many other OECD countries, however, Australia does not make employment issues an integral part of mental health treatment. Providers (who include GPs) do not generally address work in their treatment plans. Nor do the clinical guidelines published by the Royal Australian and New Zealand College of Psychiatrists discuss employment issues. Moreover,

there is no form of collaboration across institutions and sectors with employment specialists.

Occupational health knowledge is missing in GP practices

GPs can exert a strong influence on the employment outcomes of people with mental health problems, as they are responsible for sickness certification. Certifying time off work, especially for a longer term, significantly increases rates of work disability and poor physical and mental health (OECD, 2012). However, GPs' knowledge of the relationship between mental health and work seems poor. In a study of 124 424 sickness certificates written by GPs for workers' compensation claimants in 2003-10, Collie et al. (2013) found that people with work-related mental health problems were more often deemed unfit for work. While 74.1% of all certificates declared claimants "unfit for work", the figure for mental health conditions was 94.1%. The authors argue that the difference may be attributable to:

- health care professionals' perception that people with mental health problems suffer from poorer health outcomes than is actually the case.
- limited understanding of when it is feasible to resume work,
- a shortage of available workplace accommodations.

This last suggestion is supported by research conducted in 2008 in which GPs reported concerns about the lack of supportive, flexible employers and workplaces in their localities. They consequently preferred to draw up medical certificates or reports that exempted patients with mental health problems, work-related and non-work-related, from returning to or looking for work (DEEWR, 2008). At this moment, the Australian Government has proposed new legislation to increase availability of suitable workplaces for workers' compensation claimants (i.e. workers with a work-related illness or injury) through enabling them to look beyond their current employer for suitable work while returning to work without losing the right to employment with their employer. This will, however, only affect a small group of the people with mental health problems, as most do not fall under the workers' compensation scheme (see also Chapter 4).

Postponing the early resumption of work considerably jeopardises the success of the whole return-to-work process. In fact, research has shown that the chances of returning to work shrink fast over time (OECD, 2012; Koopmans, Roelen and Groothoff; 2008). Given that most people with mental health problems are treated by their GP, the fact that they have a poor grasp of the importance of employment and provide little return-to-work support is worrying.

To improve GPs' understanding of return-to-work opportunities for people with mental health problems, other countries like Sweden and the Netherlands have drawn up guidelines on mental health and work for medical practitioners (OECD, 2015). The Swedish guidelines specifically include advice on expected lengths of sickness absence and when to recommend part-time resumption of work (OECD, 2013). As for the Netherlands, its guidelines spell out the return-to-work process step by step and advise doctors how to signal stagnation and what action to take (OECD, 2014). Such guidance can help prevent extended periods of sickness absence and so reduce the risk of work disability.

On a positive note, the Australasian Faculty of Occupational and Environmental Medicine and the Royal Australasian College of Physicians launched the "Australian and New Zealand consensus statement on the health benefits of work" in 2011. By August 2014, it had been signed by over 75 stakeholders. The statement seeks to get stakeholders to acknowledge that work is an important determinant of health and to encourage them to support the labour market participation of people with health problems. Although the statement is a high-level declaration that will not in itself shape GP behaviour, it does raise awareness of the need to invest in the positive effects of work on health.

Comcare (the workers' compensation insurer covering, primarily, Commonwealth Government employees) in collaboration with other insurers in the Australian Capital Territory (ACT) has followed the UK's lead to replacing "sick notes" with "fit notes", designed to emphasise what sick or injured people are still able to do instead of what they cannot do. This approach builds on the evidence that, in general, work is good for health and wellbeing. The new certificate that now focuses on capacity instead of incapacity is in use by a number of GPs in the ACT and surrounding region. Guidance for GPs on using the certificate is provided on Comcare's website.[4] Additionally, Comcare is exploring how "GP return to work case conferencing" – a meeting between the GP, patient, supporting individual, rehabilitation provider and the employer to communicate requirements for recovery at work in case of a workers' compensation claim – can be used in order to help employees recover at work more efficiently and with proper support. If successful, such an approach might also be extended to non-work related illnesses and injuries.

Employment support for people with mental illness focuses only on severe disorders

Although measures to support employment and mental health seldom connect, some programmes have emerged that bring them together:

specifically, Partners in Recovery, Personal Helpers and Mentors, and Individual Placement and Support.

The Commonwealth Government, states and territories, and NGOs all deliver programmes for people with mental illness and their carer. They are not, however, aligned with each other. Partners in Recovery (PIR) seek to strengthen support for people, and their carer, who suffer from severe, persistent mental illness and have complex needs. The additional focus on carers is important as research has shown that one third of carers experience severe depression (beyondblue, 2009), and caring for a person with a mental health problem worsens work and financial circumstances (e.g. reduced working hours) for over 50% of carers (National Mental Health Commission, 2012). The approach of PIR is to bring multiple sectors and services together to work in a more collaborative, integrated manner. The Commonwealth provided a budget of AUD 549.8 million for PIR for the period 2011-12 to 2015-16 (Department of Health and Ageing, 2013b).[5] By way of comparison, the budget for ATAPS was AUD 205.9 million for the same period (Commonwealth Government, 2011). NGOs can apply for funds to set up a PIR unit within a Medicare Local jurisdiction. They must use the money to support the following objectives:

- Facilitate co-ordination between clinical care and other forms of support and services,
- Strengthen partnerships and build better links between clinical care providers and community support organisations,
- Improve referral pathways,
- Promote a community-based recovery model.

Services and support in PIR programmes need to address issues like mental health and wellbeing, physical health, housing and accommodation, education, income support, and employment support (Department of Health and Ageing, 2013b). Currently, 48 NGOs have implemented a PIR programme. Although no information on their results has been published yet (and, therefore, no conclusions drawn), an evaluation is currently under way.[6]

The Personal Helpers and Mentors (PHaMs) programme is also a channel through which the Commonwealth Government funds NGOs to provide assistance to people with severe mental health problems. PHaMs helps these people to better manage different aspects of their lives and overcome barriers to social and economic participation. It seeks specifically to help them participate more fully in society by strengthening their connections with the community. The programme started in 2007 and continues to receive funding until 2016.

A unique feature of PHaMs is that, since July 2013, it also arranges employment support for those programme participants who are in receipt of the Disability Support Pension or other government income-support payment since. PHaMs Employment Services employ specialist employment consultants who work on non-vocational barriers to entering and staying in work, training or education. The employment services also work with PHaMs providers to better assist clients seeking to enter employment or training and with employment specialists to improve their guidance of jobseekers with severe mental illness (Department of Social Services, 2013).

In 2011, an evaluation of PHaMs was carried out (before PHaMs Employment Services was implemented), but employment outcomes were outside the scope of the evaluation. It chiefly addressed client and server provider experiences, how clients access services, and how collaborative working was put in place (Department of Families, Housing, Community Services and Indigenous Affairs, 2011). It would be interesting to have an additional evaluation of the PHaMs Employment Services programme to see whether it is successfully in reducing barriers to finding and maintaining employment, training or education.

As it has in many other Western countries, Individual Placement and Support (IPS) for people with severe mental disorders has now made its way to Australia. IPS is a detailed treatment model in which employment support is fully integrated into mental health care – with employment specialists working alongside mental health care providers – and has a well-established evidence base (Kinoshita, 2013).

A particular challenge in the Australian context is that states and territories fund and organise specialised mental health services while employment services are supplied by private firms contracted by the federal government (Orygen Youth Health Research Centre, 2014). Mental health carers may therefore need to set up partnerships with local employment services that have approaches to service delivery that are different from what is stated in IPS protocols. Implementation and outcomes may suffer as a consequence. For example, Morris et al. (2014) found that four different locations showed strong compliance with IPS principles, but that factors other than compliance – such as employment specialist skills or clinical care leadership – appeared to contribute to employment outcomes.

To improve implementation of IPS, specifically for young people, the Commonwealth Government has provided funding for a national trial of the IPS model from 2015 to 2019 for young people with mental illness up to age 25. The trial will be progressively implemented in up to 15 youth mental health services nationally and will include a comprehensive research evaluation component. Once fully implemented, the trial should have the

capacity to assist approximately 2 000 young people with mental illness each year.

All the schemes described above focus on people with severe mental disorders. There are no examples of initiatives in the mental health sector that address employment issues for those with mild-to-moderate mental health problems. This is a concern as people with mild-to-moderate problems form a much larger group with good employment potential. Equally, they may well be in work and thus directly confronted with work-related issues that need to be addressed.

For such people, however, policies – like the various National Mental Health Plans – seek primarily to enable better access to mental health care services. They do not include ways of bringing an employment focus into mental health care. For example, as described earlier in this chapter, some initiatives (like Better Access) have sought to incorporate mental health treatment into primary care settings, but this has not been followed by action to bring employment support into primary care. Similarly, the 10-year Roadmap for National Mental Health Reform stresses that mental health reform must cross sectors and service settings. However, it lacks any indications as to how to implement such a collaborative approach. And there are no (financial) incentives in the system to that end.

Recent policy changes in the United Kingdom to integrate health care and employment support for people with mild-to-moderate mental disorders might also be workable in Australia. For example, the Outcomes Framework of the United Kingdom's National Health System has put in place two work-related quality indicators for mental health care delivery: the patient's employment status and sickness absence days. In addition, its Increasing Access to Psychological Therapies programme (which bears a resemblance to ATAPS), incorporates the services of an employment advisor – a good example of an integrated form of mental health and work support (Box 2.4).

Box 2.4. **Integrated employment support and mental health care: An example from the United Kingdom**

To provide integrated employment and health services, employment advisors were introduced in the Improving Access to Psychological Therapies (IAPT) services in the United Kingdom. IAPT services were put in place to ensure fast access to evidence-based psychological treatment for people with a common mental disorder. The employment advisors work alongside the IAPT therapists, providing practical advice and relevant intervention to help people remain in work or enter the workplace. Access to IAPT services is by self-referral or referral from the GP.

Box 2.4. **Integrated employment support and mental health care: An example from the United Kingdom** *(cont.)*

An evaluation of the added value of the services provided by employment advisors showed that it enabled clients to address the employment-related problems they faced – often by including the employer in finding solutions. Clients also mentioned that they experienced improvements in their sense of achievement and job satisfaction, and they concluded that the employment support had helped them to stay in employment.

Source: Hogarth, T. et al. (2013), "Evaluation of Employment Advisers in the Improving Access to Psychological Therapies Programme", Department for Work and Pensions, London.

Round-up and recommendations

Mental health has been a key policy priority for the Australian Government over recent decades. It has drawn up many policy plans and funded a number of programmes to improve the treatment of mild-to-moderate mental disorders.

Nevertheless, there is still an imbalance between mental health treatment demand and supply. The latest estimate representative of the population in need of treatment was in 2007. It found that 22% of the people with a mental disorder who perceived a need for treatment felt this need was not met. Among those who received treatment, 41% stated that their needs had been only partly met.

Reaching out to people in remote areas has been particularly problematic even though policy has made it a main target. The ATAPS programme in particular received special funding for increasing the provision of mental health care in remote areas. Nevertheless, only a small increase in treatment rates has been observed over the years in those parts of the country. What's more, long-distance outreach, such as videoconferencing and telephone- and web-based therapies, are only rarely used. Potentially, the recently launched "E-mental health in practice" initiative by the Australian Government, might improve uptake of web-based therapies by increasing engagement of health professionals in the use of such programmes by patients.

Another challenge is to ensure a focus on employment among mental health care providers. The authorities have been taking a number of promising first steps towards fostering a common understanding among health care providers that work is good for health. One example is the change from "sick notes" to "fit notes", whereby GPs medical certificates state whether workers with mental health problems are fit to resume work,

rather than how sick they are. Nevertheless, GPs lack adequate knowledge of how mental health and work mutually affect each other, and how support can help people with mental health problems keep their jobs. There are a few programmes outside the primary care setting that demonstrate how to incorporate an employment focus into the mental health care setting. Such schemes are, however, directed solely at people with severe mental disorders.

Ensure high-quality treatment

- *Increase the use of psychologists and other mental health professionals.* So far, the Better Access programme has chiefly produced a sharp increase in GP-provided mental health services. But GPs are still not well trained in mental health skills and have less time to treat patients with mental health issues than other mental health professionals, such as psychologists. Access to and use of allied mental health professionals under the Better Access initiative could be improved by allowing self-referral, as has been done in the United Kingdom as part of Increasing Access to Psychological Therapies programme. To prevent over-use of Medicare-rebated mental health services, diagnosis of a mental disorder at the first appointment with a mental health professional could be a prerequisite.

- *Improve mental health care provided by GPs.* GPs prescribe psychotropic medication much more widely than they use counselling therapy, even though counselling produces good outcomes among people with mild-to-moderate mental disorders. Moreover, GPs provide only limited mental health care. They should be encouraged to offer more counselling – by paying them more to do so, for example – or to refer more patients to mental health care specialists. To help GPs treat people with mild-to-moderate mental disorders, the Mental Health Nurse Incentive Programme, which funds GPs to employ mental health nurses, could be extended to such patients.

- *Promote the use of telephone and web-based therapies.* Despite the wide availability and low costs of telephone- and web-based therapies under the ATAPS programme, and although the evidence base is positive, they are used only rarely. Understanding why there is so little uptake and finding ways to better promote remote therapies could help to substantially increase treatment rates in outer regions of Australia.

- *Follow-up on the Primary Health Networks to ensure collaboration between primary and specialised care.* The Primary Health Networks (PHNs) that have been introduced in July 2015 are one more attempt to better co-ordinate collaboration between primary and specialised care.

The PHNs' predecessors, the Medicare Locals, were also created to integrate health care across the system, but fell short. It will be essential to closely monitor the PHNs against clear performance indicators that measure instances of successful collaborative care (e.g. quick referrals from primary to specialised care and shorter total treatment time).

Develop employment knowledge in the GP practice

- *Include employment issues in GP mental health training.* As many GPs sign up to training in mental health skills, courses would be an ideal setting for fostering understanding of the importance of work for good mental health and discussing employment issues with patients. GPs could also be trained in how to assess the capacity to work of people with mental health problems.
- *Develop guidelines for sickness certification.* GPs' sick leave certificates can keep people with mental health problems in or out of work. It is paramount, therefore, that they have a common frame of reference for assessing the capacity to work of employees with mental health conditions who may well be at different stages of recovery. Guidelines on sickness certificates for people with mental disorders, comparable to those for GPs in Sweden, could help GPs to make evidence-based decisions.
- *Assist GPs in providing employment support.* An initiative similar to the Mental Health Nurse Incentive Programme could help GPs support patients with mental health problems in their employment issues. Occupational therapists or employment specialists could play a role similar to that of mental health nurses, monitoring patients' capacity to work, offering them counselling, and keeping them connected with the workplace.

Extend employment support in mental health care to people with mild-to-moderate mental disorders

- *Extend ATAPS and Better Access with the addition of employment support.* Within the mental health care sector, solely people with severe mental disorders receive employment support. However, those with mild-to-moderate mental disorders are often actually in work and struggling to stay there. The ATAPS and Better Access initiatives have shown their efficacy in increasing the treatment rate of people with mild-to-moderate mental disorders and are ideally suited to bringing in employment support at an early stage – i.e. before people start claiming disability benefit, or even before they fall sick. The United Kingdom's

experience of incorporating employment support into a similar mental health care programme is a good starting point.

- *Include quality indicators on employment in mental health care.* To ensure that employment support in mental health care is successful, policy should incorporate meaningful employment outcomes into mental health care quality indicators. Such indicators could be a patient's employment status or number of sickness absence days, as in the Outcome Framework of the National Health System England.
- *Explore ways to ensure system-wide collaboration in improving employment outcomes.* Comparable to the Partners in Recovery programme, multiple sectors and services should come together to work in a more collaborative, co-ordinated, and integrated way in order to support people with mild-to-moderate mental disorders. Given the high work potential of such people, a strong focus on employment is warranted. To that end, the possibility of a "Partners in Employment" programme could be explored.

Notes

1. Patients may have benefitted from more than one type of service or medication but were counted only once in the totals.
2. Of the total Australian population, 66% live in cities, 21% in inner regional areas, 10% in outer regional areas, 2% in remote areas, and 1% in very remote areas. www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442459572 (accessed 2 September 2015).
3. For further details see www.emhprac.org.au (accessed 2 September 2015).
4. For further details see www.comcare.gov.au/promoting/health_benefits_of_work_programme/better_practice (accessed 2 September 2015).
5. For the years 2013-14 and 2014-15, however, the Commonwealth Government cut the budget for the PIR program by AUD 53.8 million.
6. For a description of Partners in Recovery programme, go to its website at www.health.gov.au/internet/main/publishing.nsf/Content/mental-pir-eval (accessed 2 September 2015).

References

AIHW – Australian Institute of Health and Welfare (2014), *Mental Health Services in Australia*, Australian Institute of Health and Welfare, http://mhsa.aihw.gov.au/home/ (accessed 2 September 2014).

Bassilios, B. et al. (2013), *Evaluating the Access to Allied Psychological Services (ATAPS) Component of the Better Outcomes in Mental Health Care (BOiMHC) Program*, Ten year consolidated ATAPS evaluation report, University of Melbourne, Melbourne.

Beyondblue (2009), "The Beyondblue Guide for Carers: Supporting and Caring for a Person with Depression, Anxiety and/or Related Disorder", beyondblue, Melbourne.

Burgess, P. et al. (2009), "Service Use for Mental Health Problems: Findings from the 2007 National Survey of Mental Health and Wellbeing", *Australian and New Zealand Journal of Psychiatry*, Vol. 43, pp. 615-623.

Butler, A. et al. (2005), "The Empirical Status of Cognitive-behavioral Therapy: A Review of Meta-analyses", *Clinical Psychology Review*, Vol. 26, pp. 17-31.

Christensen, H., K. Griffiths and L. Farrer (2009), "Adherence in Internet Interventions for Anxiety and Depression: Systematic Review", *Journal of Medical Internet Research*, Vol. 11, No. 2, p. e13.

COAG – Council of Australian Governments (2012), *The Roadmap for National Mental Health Reform 2012-2022*, Council of Australian Governments, Canberra.

COAG (2011), *National Health Reform Agreement*, Council of Australian Governments, Canberra.

Collie, A. et al. (2013), "Sickness Certification of Workers Compensation Claimants by General Practitioners in Victoria, 2003-2010", *Medical Journal of Australia*, Vol. 199. No. 7, pp. 480-483.

Commonwealth Government (2011), "National Mental Health Reform - Ministerial Statement", Commonwealth of Australia, Canberra.

DEEWR – Department of Education, Employment and Workplace Relations (2008), *Communication with General Practitioners to Support the Employment of People with Mental Illness*, Commonwealth of Australia, Canberra.

Department of Families, Housing, Community Services and Indigenous Affairs (2011), "Working with Australians to Promote Mental Health, Prevent Mental Illness and Support Recovery", Evaluation of the FaHCSIA targeted community care mental health initiatives, Final report, Commonwealth of Australia, Canberra

Department of Health and Ageing (2013a), *National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993-2011*, Commonwealth of Australia, Canberra.

Department of Health and Ageing (2013b), *Partners in Recovery (PIR): Coordinated Support and Flexible Funding for People with Severe, Persistent Mental Illness and Complex Needs Initiative: Operational Guidelines for PIR Organisations*, Commonwealth of Australia, Canberra.

Department of Health and Ageing (2012a), *Evaluation of the Mental Health Nurse Incentive Program: Final Report*, Commonwealth of Australia, Canberra.

Department of Health and Ageing (2012b), *Operational Guidelines for the Access to Allied Psychological Services Initiative*, Commonwealth of Australia, Canberra.

Department of Health and Ageing (2010a), *National Mental Health Report 2010: Summary of 15 Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2008,* Commonwealth of Australia, Canberra.

Department of Health and Ageing (2010b), *Outcomes and Proposed Next Steps: Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program*, Commonwealth of Australia, Canberra.

Department of Social Services (2013), "Part C1: "Personal Helpers and Mentors Guidelines under the Targeted Community Care" (Mental Health Program), Commonwealth of Australia, Canberra.

Dwyer, J. and K. Eager (2008), "Options for Reform of Commonwealth and State Governance Responsibilities for the Australian Health System", Paper commissioned by the National Health and Hospitals Reform Commission.

Ejeby, K. et al. (2014), "Symptom Reduction Due to Psychosocial Interventions Is Not Accompanied by a Reduction in Sick Leave: Results from a Randomised Controlled Trial in Primary Care", *Scandinavian Journal of Primary Health Care*, Vol. 32, No. 2, pp. 67-72.

General Practice Mental Health Standards Collaboration (2013), *Mental Health Education Standards 2014-2016: A Handbook for GPs*, The Royal Australian College of General Practitioners, Melbourne.

Hogarth, T. et al. (2013), *Evaluation of Employment Advisers in the Improving Access to Psychological Therapies Programme*, Department for Work and Pensions, London.

Horvath, J. (2014), "Review of Medicare Locals", Report to the Minister for Health and Minister for Sport.

Kinoshita Y. et al. (2013), "Supported Employment for Adults with Severe Mental Illness", *Cochrane Database of Systematic Reviews*, No. 9, pp. 1-72.

Koopmans, P., C. Roelen and J. Groothoff (2008),"Frequent and Long-term Absence as a Risk Factor for Work Disability and Job Termination Among Employees in the Private Sector", *Occupational and Environmental Medicine*, Vol. 65, pp. 494-499.

Meadows, G. and P. Burgess (2009), "Perceived Need for Mental Health Care: Findings from the 2007 Australian Survey of Mental Health and Wellbeing", *Australian and New Zealand Journal of Psychiatry*, Vol. 43, pp. 624-634.

Medibank and Nous Group (2013), *The Case for Mental Health Reform in Australia: A Review of Expenditure and System Design*, Medibank Private Limited and Nous Group.

Melville, K., L. Casey and D. Kavanagh (2010), "Dropout from Internet-based Treatment for Psychological Disorders", *British Journal of Clinical Psychology*, Vol. 49, pp. 455-471.

Morris, A. et al. (2014), "Implementation of Evidence-based Supported Employment in Regional Australia", *Psychiatric Rehabilitation Journal*, Vol. 37, No. 2, pp. 144-147.

National Mental Health Commission (2012*), A Contributing Life: The 2012 National Report Card on Mental Health and Suicide Prevention*, National Mental Health Commission, Sydney.

OECD (forthcoming), *Australia – Mental Health Analysis Profile (MhAP)*, OECD Publishing, Paris.

OECD (2015), *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work*, Mental Health and Work, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264228283-en

OECD (2014), *Mental Health and Work: Netherlands*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264223301-en.

OECD (2013), *Mental Health and Work: Sweden*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264188730-en.

OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264124523-en.

Orygen Youth Health Research Centre (2014), *Tell Them They're Dreaming: Work, Education and Young People with Mental Illness in Australia*, Orygen Youth Health Research Centre, Parkville.

Pirkis, J. et al. (2011), *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summary Evaluation*, University of Melbourne, Melbourne.

Spek V. et al. (2007), "Internet-based Cognitive Behaviour Therapy for Symptoms of Depression and Anxiety: A Meta-analysis", *Psychological Medicine*, Vol. 37, pp. 319-328.

van Ballegooijen, W. et al. (2014), "Adherence to Internet-based and Face-to-Face Cognitive Behavioural Therapy for Depression: A Meta-analysis", *PLoS ONE*, Vol. 9, No. 7, p. e100674.

Database references

OECD Health Database, Pharmaceutical Market dataset, http://dotstat.oecd.org/Index.aspx?DataSetCode=HEALTH_PHMC#.

Chapter 3

Mental health support for young Australians and their transition from school to work

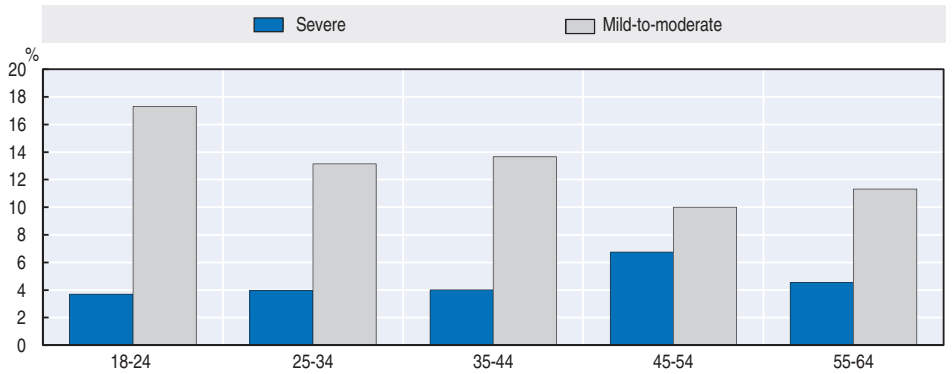
This chapter assesses the capacity of Australia's school and youth care system to support mental wellbeing among young people and assure timely support for those who face mental health problems. It then goes on to discuss actions to prevent early school leaving. The chapter ends with an examination of measures to ease the school-to-work transition and efforts to stimulate labour market participation among young adults with mental disorders.

Fifty per cent of all mental disorders begin by the age of 14 (Kessler et al., 2005). Childhood and adolescence are thus crucial periods for fostering good mental health and taking early action at the first suspicion of a problem. Failure to act early adversely affects children's performance in school and, consequently, their professional and social life as adults. Teachers and educational support professionals like school health and youth guidance counsellors have a critical role to play. Furthermore, as young people with mental health problems are more likely to show poor educational attainment, leave school early, and are less often in work, supporting them in their school-to-work transition is indispensable.

Mental illness is the single biggest health issue facing young Australians aged between 16 and 24 years old. Nationally, 26% of young people within this age bracket have experienced a mental disorder in the past 12 months (ABS, 2008). Mental illness accounts for nearly 50% of the burden of disease in that age group, with anxiety and depression being the most common disorders (Begg et al., 2007). Mental disorders are also more prevalent among the young than among adults: about one in four compared to one in five (Figure 3.1). And even among young people who never suffered from mental disorders, 24% experience moderate or severe psychological distress (Muir et al., 2009).

Figure 3.1. **The prevalence of mental disorders in Australia is at its highest among 18 to 24 year-olds**

Prevalence of a mental disorder by age and severity of disorder, 2011-12



Source: OECD calculations based on the Australian National Health Survey 2011-12.

StatLink http://dx.doi.org/10.1787/888933287565

This chapter seeks to assess how effective Australia's available youth support structures are at promoting mental wellbeing among young people, providing early support when mental health issues arise, preventing early school leaving, and smoothing the transition into employment.

Mental health and the education system

Schools are a unique setting for implementing policies that seek to foster mental health and secure a strong foundation for future employment paths. They are ideally placed for spotting and signalling poor mental health and providing first-time support, as many young people are reluctant to go to the mental health services of their own volition (Ivancic et al., 2014). To help understand the context, Box 3.1 briefly describes the Australian education system.

Box 3.1. **The Australian education system**

State and territory governments have authority over their own education systems in Australia. They fund public schools and provide some of the funding for non-government, or private, schools. Schools enjoy considerable autonomy and may allocate their budgets and implement programmes according to their needs. If, for example, they receive a budget for hiring a social worker, psychologist, or career advisor, they are free to decide how to use that professional support. As a result, service provision differs substantially both across states and across schools within states. The challenges arising from such complex governance and funding structures are partially overcome by formal agreements between the Commonwealth and state and territory governments that cover legislation, funding, and policy objectives. For example, the 2009 National Partnership Agreements for More Support for Students with Disabilities sets the national policy framework for delivering the support, learning experience, and educational outcomes that students with disabilities are entitled to in mainstream schools.

Although states and territories have different school systems, they all provide a preparatory year, followed by primary schooling (from Year 1 to Year 6 or 7, depending on the state or territory), secondary schooling (from Year 7 or 8 to 10) and, finally senior secondary school (from Year 11 to 12). Students may then go on to higher education or vocational education and training (VET). Compulsory schooling starts at 6 years old in all states and territories except Tasmania where the age is 5. All children must attend school until they complete Year 10 and be in full-time education, training, employment, or a combination thereof, until the age of 17.

School support structures for pupils with mental health problems

Australian school students with disabilities are protected, on one hand, by Commonwealth and state or territory legislation to prevent discrimination and ensure human rights and, on the other hand, by the Disability Standards for Education 2005 (known as "the Standards"). Governed by the Commonwealth Disability Discrimination Act 1992 (DDA), the Standards set out the obligations of education and training service providers and the rights of people with disabilities in education and training (Ministry of Education, Science and Training; 2006).

The Australian Curriculum, Assessment and Reporting Authority (ACARA) assists schoolteachers in meeting their obligations under the Standards and the DDA. ACARA issues advice to principals, schools and teachers to ensure that all students with a disability participate in the Australian Curriculum on the same footing as their peers. Such legislative instruments afford strong protection to young people with physical, intellectual and severe mental disabilities against any barriers to their full inclusion in education. However, there are no such provisions in place for students who suffer from mild-to-moderate mental health problems, despite their high prevalence.

Individual schools may use counselling to meet the needs of students with mild-to-moderate mental health complaints. It is supplied by trained school psychologists and counsellors who have similar qualifications across states and territories (from here on they are both referred to as school counsellors).

School counsellors support students, teachers, school staff, and parents to ensure students' proper social and emotional development and educational attainment. Counsellors prevent (by fostering mental health), assess (through diagnostic tests, for example), and intervene (through counselling and behaviour management action). They also train teachers and other school staff and are involved in planning educational strategies (Urbis, 2011; Campbell and Colmar, 2014).

Counselling delivery models vary from school to school and between states and territories. Counsellors may be based in schools as part of a team or go out to establishments when called. In 2013, Australia had over 2 000 school counsellors with ratios ranging from 1 to 1 050 students in New South Wales to 1 to 3 500 in South Australia (Campbell and Colmar, 2014). Such ratios place high demands on counsellors given that 25% of young people suffer from mental health problems and that poor mental health is the main reason for students seeking help. Not surprisingly, school counsellors report struggling with their workloads (Campbell and Colmar, 2014).

States and territories make use of a wide range of other support services to help students grappling personal problems, for example (Urbis, 2011):

- All states and territories – the National School Chaplaincy Programme. The Australian Government has committed AUD 243.8 million over four years from 2014-15 to 2017-18 to assist approximately 2900 schools engage the services of a school chaplain who will deliver pastoral care.[1] The school chaplains' qualifications requirements include competencies in mental health and making appropriate referrals.
- New South Wales – school learning and support teams. Team members comprise a co-ordinator (usually a school executive), school counsellor, class teachers, a learning support teacher and, if need be, an allied professional.
- Australian Capital Territory – Student Welfare Pastoral Care Package. Fosters student wellbeing through counselling, welfare services, and support programmes. Every school has a pastoral care co-ordinator who manages programmes.
- Northern Territory – Positive Learning Centres (PLCs). The PLC programme is for students with extreme and challenging behaviour that requires intervention.

Because of the wide variety of school support systems for students with mental health issues from one state or territory to another, and because schools are free to organise them as they see fit, there are little national data on their accessibility, adequacy and effectiveness. Such data would be highly valuable as school appears to be one of young people's first ports of call in the event of problems. Mission Australia's Youth Survey 2014 (including 13 600 subjects aged 15 to 19 nationwide) found that young people would sooner seek help from the school system than community services – 36% would go to their teacher, 34% to their school counsellor, and only 10% to the community services (Fildes et al., 2014). For a proper assessment of the quality of youth care in Australia, data on the support provided within schools are indispensable.

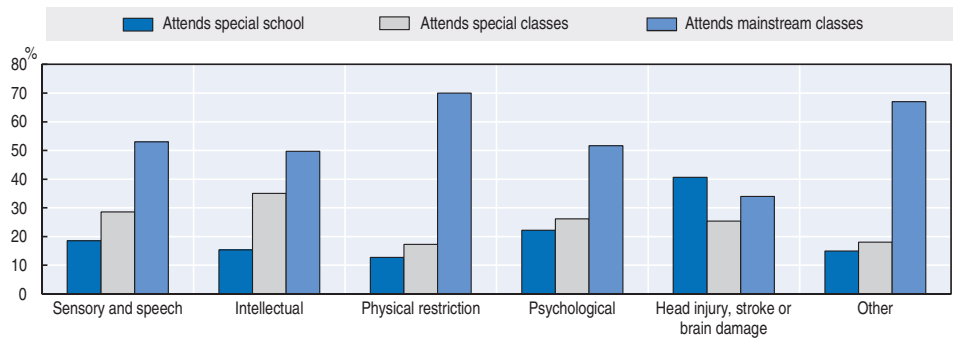
Special education

Students enrolled in special schools struggle with challenges like mental and physical disability or impairment, slow learning ability, social or emotional problems, and custody, remand, and/or hospitalisation. Special schools include Special Assistance Schools, as defined under the Schools Assistance Act 2008, which specifically cater for students with social, emotional or behavioural difficulties.

Australia has an inclusive approach to education for children and young people with special needs, encouraging them to attend mainstream establishments as much as possible. Nevertheless, data from the Australian Bureau of Statistics (ABS, 2009) show that children with psychological disorders are more likely than their peers with other disabilities to be in special schools (Figure 3.2) – while 78% do attend general schools (52% in mainstream classes and the remainder in special classes), the share of all children with any disability is 90%.

Figure 3.2. **Children with psychological disabilities are among the most likely to attend a special school**

Children with disability attending school, by type of school attended and disability



Note: The "psychological" category includes: i) nervous or emotional conditions that restrict everyday activities, and ii) mental illness or condition requiring help or supervision.

Source: ABS (2009), "44290DO006_2009 Disability, Ageing and Carers, Australia 2009: Profiles of Disability", Australia, Table 8.

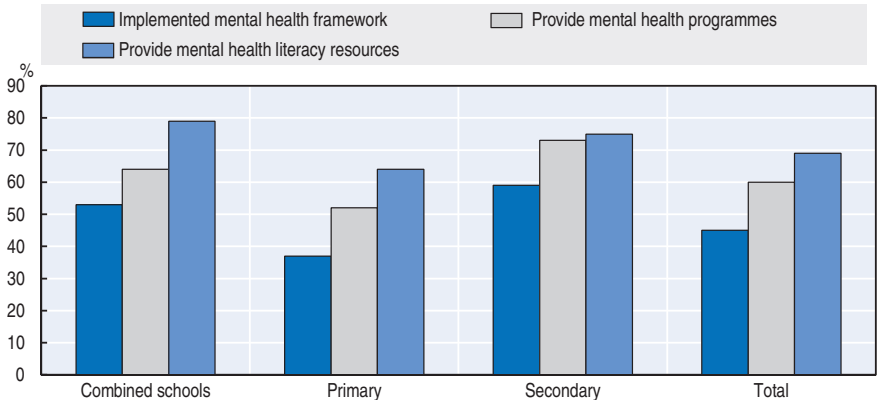
StatLink http://dx.doi.org/10.1787/888933287575

Strong investment in mental health promotion in schools

Whereas school support services for young people with mental health problems varies on a national level, mental health promotion is organised more coherently. A reason for this may be that it is a national priority, with the Fourth National Mental Health Plan and its predecessors emphasising the importance of general mental health promotion and improved mental health literacy in early childhood education and care (ECEC) services and primary and secondary schools. In 2011, 60% of Australian schools ran mental health promotion programmes. Similarly, even though broader mental health frameworks did not always incorporate mental health literacy resources, 69% of schools had them in their curricula (Figure 3.3).

Figure 3.3. **Most schools invest in mental health promotion**

Percentage of schools reporting implementation of mental health frameworks, programmes, and literacy resources, by school type



Source: Department of Health and Ageing (2013), *National Mental Health Report 2013: Tracking Progress of Mental Health Reform in Australia 1993-2011*, Commonwealth of Australia, Canberra.

StatLink http://dx.doi.org/10.1787/888933287580

The importance of promoting mental health among children even before they join primary education is lent further weight by the broad agenda of the Council of Australian Governments (COAG) for improving the quality of ECEC services. However, a review of ECEC workers' competencies in addressing children's mental health and wellbeing found that, while the daily work of early childhood educators generally contributes to mental health outcomes, mental health promotion is not formally articulated in practice or in training and development. The reviewers thus recommended measures to promote mental health literacy and strengthen mental health training in the ECEC sector (Hunter Institute of Mental Health and Community Services and the Health Industry Skills Council, 2012).

School-based mental health promotion programmes

The most widely recognised school-based mental health framework initiatives in Australia are *KidsMatter* (for ECEC services and primary schools) and *MindMatters* (for secondary schools). Funded by the Australian Government through the Department of Health and developed in collaboration with *beyondblue* (an independent, non-profit organisation addressing mental health issues), the Australian Psychological Society, and Principals Australia Institute, both programmes draw on the Health Promoting Schools' framework of the World Health Organization (WHO).

KidsMatter

*KidsMatte*r broadly aims to improve mental health outcomes for children in a holistic manner by enhancing protective factors, increasing childrens' resilience and skills in self-regulation and encouraging partnerships between education, early childhood, and health and community sectors to facilitate early intervention in the child's life where necessary.

The *KidsMatter* initiative comprises *KidsMatter Early Childhood*, delivered in ECEC services, and *KidsMatter Primary*, delivered in Australian primary schools. *KidsMatter Early Childhood* seeks to:

- Inform and support early childhood education and care practice and quality requirements;
- Provide resources, tools, and opportunities for thought;
- Connect educators, children, families, school management, community and health professionals.

KidsMatter Primary uses a whole-school approach to improve mental health and wellbeing, reduce mental health problems, and facilitate access to services in the event of mental health problems among primary school pupils. It works with a conceptual framework to assess risk and protective factors for children's mental health. The framework consists of four school-based components:

1. positive school community,
2. social and emotional learning for students,
3. parenting support and education,
4. and early intervention for students experiencing mental health difficulties.

The framework rests on the importance of collaboration between schools, parents, and the health sector (Slee et al., 2009).

Pilots and comprehensive evaluations of both *KidsMatter* initiatives were conducted between 2007 and 2011 (Box 3.2). The evaluations found that the effect on children already grappling with mental health issues was positive, and mental wellbeing was maintained in children who did not experience mental health difficulties. One drawback was that comparison groups were not part of the programme evaluations, restricting the validity of the assessment of *KidsMatter's* true impact. In addition, the *KidsMatter* approach is one of promotion, prevention and early intervention for which outcomes would have to be assessed in a longer time period than the two-year duration of the evaluations carried out to date.

Box 3.2. **Evaluations of *KidsMatter Early Childhood* and *KidsMatter Primary***

KidsMatter Early Childhood

Between 2009 and 2011, *KidsMatter Early Childhood* was trialled in a nationwide pilot. Flinders University conducted an evaluation of the pilot, published in 2012. It covered the 111 ECEC services where the pilot was run across all states and territories in urban and remote areas, and questioned a total of 1 194 school staff and 5070 parents and caregivers. Important outcomes measured were:

- Staff having the knowledge, competence, and confidence to support the development of children's social and emotional skills and to help children with mental health issues;
- Children's mental health and wellbeing and mental health difficulties.

Mental health outcomes for children were measured by the internationally used Strengths and Difficulties Questionnaire (SDQ), designed by Goodman (2005). The children who experienced mental health difficulties on inception of the pilot programme showed significant improvement. Those with normal mental health scores showed no change in mental health difficulties. Educators' rating of their understanding and ability to support mental health in early childhood improved significantly, as did their knowledge of children's mental health (Slee et al., 2012).

KidsMatter Primary

A pilot phase of *KidsMatter Primary* was trialled in 100 schools across Australia during 2007-08. The evaluation examined the impact of the initiative on schools, teachers, parents and students. Per school, it surveyed the parents of up to 76 students with a target age of 10 years old at three time points, and the students' teachers at four. It placed special emphasis on the impact on student mental health, with the primary mental health measure also being the SDQ. A 70% response rate among parents yielded questionnaires for 4 980 primary school students.

The evaluation also included qualitative analyses drawn from reports by *KidsMatter Primary* project officers and school principals and from 64 interviews and 44 focus group discussions conducted with school leaders, teachers, parents and students.

There was a general improvement in student mental health and wellbeing. Children's social and emotional competencies as assessed by parents and teachers improved significantly over time, although effect sizes were limited. The improvement was also confirmed through interviews with students.

Similarly, significant changes over time in pupils' mental health difficulties were found. Although effect sizes were small for the group as a whole, they were medium and large for the group of pupils with borderline and abnormal scores on mental health difficulties.

With regard to teachers' professional skills in mental health, there was moderate success. For example, 14% strongly agreed that they knew how to help students in developing social and emotional competencies, while 11% strongly agreed that they felt effective in dealing with students' mental health issues (Slee et al., 2009).

As at April 2015, *KidsMatter Primary* operates in 2 550 primary schools (Table 3.1). This equates to around 30% of primary schools nationally. *KidsMatter Early Childhood* is yet to be expanded nationally. There were 274 ECEC services participating in the initiative as at April 2015. The minimum target is to have 3 000 primary schools and 380 ECEC services participating by June 2016.

Table 3.1. **Number of primary schools participating in *KidsMatter Primary* per state and distribution by region, 2013**

As at July 2013	ACT	New South Wales	Northern Territory	Queensland	South Australia	Tasmania	Victoria	Western Australia	Nationally
KidsMatter Primary Schools	67	560	88	440	291	129	612	363	2 550
Metropolitan	99%	68%	0%	53%	48%	40%	59%	50%	55%
Provincial	1%	31%	36%	42%	44%	56%	41%	33%	38%
Remote and Very Remote	0%	1%	64%	6%	9%	4%	1%	17%	7%
Total number of primary schools	101	2 412	162	1 393	617	211	1 783	896	7 575

Source: Information provided by the Department of Health, Commonwealth of Australia, Canberra.

StatLink http://dx.doi.org/10.1787/888933287824

MindMatters

The *MindMatters* initiative seeks to increase a secondary school's capacity to implement a "whole-school" approach to mental health promotion, prevention, and early intervention and the initiative has been operating for more than 15 years (Wyn et al., 2000). Originally, the programme had three areas of focus (Urbis, 2011):

- School ethos and environment, e.g. resources, co-ordination and structuring at the school level;
- Curriculum, e.g. teaching and learning for engagement;
- Internal and external partnerships and services, e.g. partnerships with the community and parents, management of school transitions.

While *MindMatters* has the potential to make a real difference in the lives of children with mental health issues, there had been no robust measurement of how it improves mental health literacy, interventions or outcomes. Nor was it known how many secondary schools had incorporated the whole-school framework.

Therefore, in 2013, the Australian Government Department of Health commissioned the redevelopment of *MindMatters* to better align it with the *KidsMatter* initiatives and to take into account the latest evidence on improving mental health outcomes in the school environment. This decision recognised the importance of realising the potential of the *MindMatters* initiative. The renewed *MindMatters* initiative has adopted the four-component framework of *KidsMatter*, duly adjusted to adolescent development in secondary schools, and has developed a comprehensive suite of online resources that are aimed at maximising engagement with secondary school teachers and other staff.[2] It was rolled out from 2014 and is freely available to all Australian secondary schools. The current target is to have reached 700 schools by June 2016. An independent evaluation will be essential to assess the success of the redeveloped initiative.

Other mental health promotion initiatives

Under the *KidsMatter* and *MindMatters* initiatives, schools can choose from a number of nationally available school-based mental health programmes, which are also available to schools not participating in *KidsMatter* or *MindMatters*. As early as 2007, Neil and Christensen reviewed the effectiveness of Australian school-based prevention and early intervention programmes for anxiety and depression. They found that a number of the programmes – such as *Aussie Optimism, Cool Kids, FRIENDS, MoodGYM*, and *Problem Solving for Life* – helped ease anxiety, depression, or both. They went on to conclude that the *FRIENDS* programme in particular, which has been evaluated in seven different trials, could well be deployed on a larger scale (Box 3.3). It has showed consistent effectiveness in a range of settings and lends itself to successful implementation by teachers (Neil and Christensen, 2007).

Box 3.3. ***FRIENDS*: Mental health promotion by teachers**

FRIENDS aims to prevent child anxiety and depression through a programme that is directed at all children and can be implemented by teachers. It combines cognitive-behavioural principles and the building of emotional resilience in an approach that seeks to teach children and young people how to cope with, and manage, anxiety.

In schools, *FRIENDS* can be targeted across a single selected grade of children and added to the school's curriculum. Teachers can purchase the programme manual and should attend a one-day training course by an accredited trainer. Workbooks for children form part of the programme.

Box 3.3. ***FRIENDS*: Mental health promotion by teachers** *(cont.)*

FRIENDS was developed in 1998 and has been revised and improved over the years. In 2005, it was redubbed "FRIENDS for Life" to reflect its long-term benefits, while a preschool version – *FUN FRIENDS* – has also been designed. The World Health Organisation has acknowledged the programme, following the positive results over 10 years of evaluation. It has been trialled and implemented worldwide.

Source: The FRIENDS programmes website, www.friendsrt.com (accessed 2 September 2015).

Mental health promotion and support in tertiary education

There is little clear information as to the provision of mental health literacy, promotion and prevention programmes in VET institutions or universities, as Australian Governments offer little incentive for improving mental health literacy among tertiary-level students and their teaching staff. Yet psychological distress is frequent among the students. The share of students suffering from moderate to high psychological distress ranges between 21% to 84%, depending on the type of student population surveyed and the psychometric instrument and cut-off score used (Cvetkovski, Reavley and Jorm; 2012). Moderate distress levels may be even higher than among non-students (Reavley, McCann and Jorm; 2012a).

While several studies have shown that students are able to recognise mental health problems and their impact (Reavley, McCann and Jorm; 2012b), disclosure and seeking professional support remain serious issues. One study on mental health literacy among higher education students (Reavley, McCann and Jorm; 2012b) found that, of the 774 students surveyed, only 26% reported that they would visit a GP if faced with mental health problems, 10% a student counsellor, and 8% a psychologist. Of the 205 who had truly experienced mental health problems, a higher proportion said they sought help, with 54% going to a GP, 42% a psychologist, and only 10% a student counsellor. The most widely sought support (at 82%) was that of a close friend (Reavley, McCann and Jorm, 2012a). Indeed, VET students are highly unwilling to disclose their mental health issues to teachers or school staff: they are anxious to protect their sense of self-reliance, self-confidence and integrity, and to prevent negative perceptions (Venville and Street, 2012).

All these findings call for greater attention to mental health promotion and prevention programmes in tertiary education. The existing provision consists mostly of online resources offered by non-profit organisations such as headspace (discussed in more detail below), *youthbeyondblue* and *ReachOut.com*. They do not, however, suffice. While they presume that

students are willing to seek their support, Reavley et al. (2012b) found only 2% of respondents intended to use online resources of *beyondblue* when faced with mental health problems.

Contrast between mental health support and promotion in education

To conclude: on the one hand mental health support within the school environment for young people who are facing mental health difficulties is poorly funded and structured at a national level. On the other hand, the Commonwealth Government's strong investment in school-based mental health promotion and prevention programmes, specifically *KidsMatter* and *MindMatters*, sets an example. They do not target only those children who have mental health problems, which helps de-stigmatising mental illness and promote help-seeking behaviours.

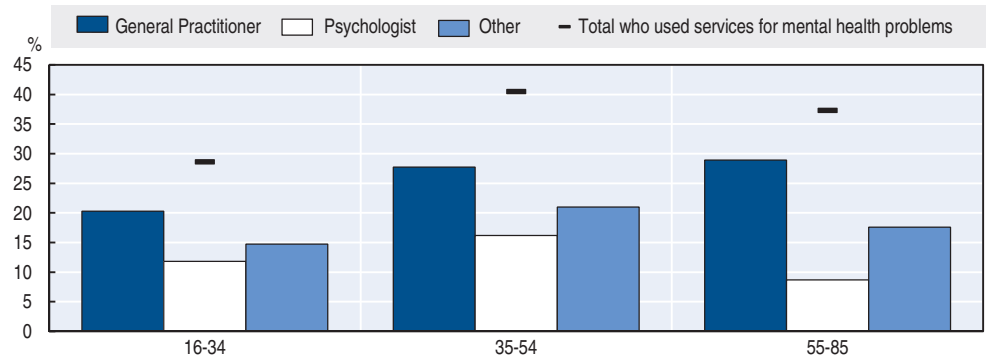
Nevertheless, the evidence-base for *KidsMatter* and *MindMatters* needs further development – no trials with a control group have been conducted, for example. It is crucial that these frameworks help schools to identify relevant mental health promotion programmes that have a strong evidence base such as, for example, the *FRIENDS* programme. Furthermore, better ways to support mental health promotion, prevention and early intervention are needed for tertiary students (potentially building on the existing primary and secondary school models for mental health promotion), as these students, too, frequently struggle with mental ill-health.

Youth mental health services

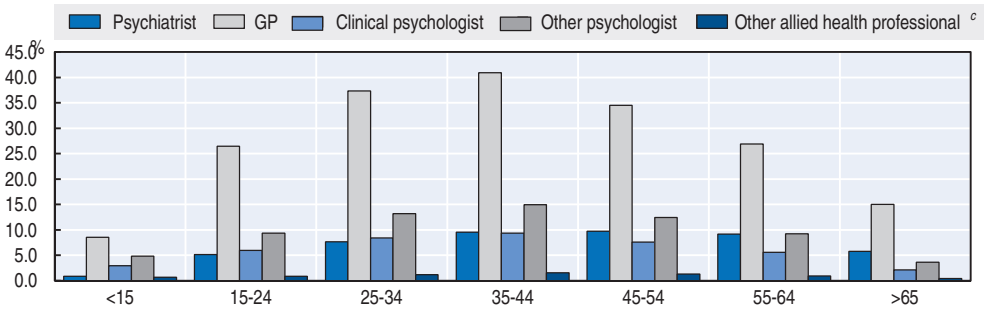
The early onset of mental health problems and their high prevalence among 12 to 25 year-olds warrants the provision of timely treatment to prevent the development of severe disorders with chronic courses (Purcell et al., 2011). Yet, young people are the least likely of all to seek mental health treatment (Figure 3.4, Panel A).

Figure 3.4. **Young people are the group least likely to receive mental health treatment**

Panel A. People with a mental disorder[a] who used health services within the previous 12 months, by age and health professional, 2007



Panel B. Share of people with mental health problems[b] receiving Medicare-subsidised mental health-related services, by age and health professional, 2011-12



a. People aged 16-85 years old who met the criteria for diagnosis of a lifetime mental disorder and had shown symptoms in the 12 months prior to interview.

b. The number of people with a mental health problem is estimated by applying the prevalence of mental health problems in each age group to the population size in that age group.

c. "Other allied health professional" includes services provided by other allied mental health professionals such as occupational therapists, social workers, and mental health nurses.

Source: Panel A – ABS (2007), "National Survey of Mental Health and Wellbeing". Panel B – OECD estimate based on data from the Australian Bureau of Statistics (2014) and Australian Institute of Health and Welfare (2012).

StatLink http://dx.doi.org/10.1787/888933287595

Mainstream mental health services do not reach out enough to the young

Government-funded mental health services available to adults also address the young. And there has indeed been a slight rise in uptake in recent years (Table 3.2).

Table 3.2. **Use of government-funded mental health services has gone up among young people**

Share of children and young people receiving Medicare-funded mental health-related services by age

	0-4 years	5-11 years	12-17 years	18-24 years Youth/young adult	All children and young people under 25 years of age
2006-07	0.1	0.7	1.1	2.2	1.1
2007-08	0.2	1.5	2.3	4.2	2.2
2008-09	0.3	2.1	3.2	5.2	3.0
2009-10	0.3	2.7	4.2	5.9	3.5
2010-11	0.4	3.2	4.9	7.0	4.2
2011-12	0.4	3.6	5.5	7.5	4.6

Source: Department of Health and Ageing (2013) *National Mental Health Report 2013: Tracking Progress of Mental Health reform in Australia 1993-2011*, Commonwealth of Australia, Canberra.

StatLink http://dx.doi.org/10.1787/888933287838

Nevertheless, young people still very seldom seek mental health treatment and remain the least likely to do so. Of people with mental health problems in each age group using Medicare-rebate services in 2011-12, only 9% of under-15s saw a GP, 3% a clinical psychologist, and 1% a psychiatrist. By contrast, the proportions were 41%, 9% and 10%, respectively, among adults aged 35-44 (Figure 3.4, Panel B). The Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (Lawrence et al., 2015) which asked about service use by young people aged 4-17 years, however, provides quite different outcomes compared to Figure 3.4, Panel B. The survey found that 53% of 4-17 year-olds with mental disorders received some form of health services for emotional or behavioural problems (i.e. any services provided by a qualified health professional regardless of where services were provided): for example, 35% visited a GP, 24% a psychologist and 7% a psychiatrist (according to parents or carers). This higher reporting rate of service use may have two explanations. First, the survey assessed the prevalence of the seven most common mental disorders among young people against the DSM-IV diagnostic criteria through face-to-face interviews. This resulted in a more

stringent definition of mental disorders and, consequently, a lower prevalence of 14% compared to the prevalence of 25% found with self-reported mental health instruments on which the data in the figure are based. The survey will therefore have included youths with more severe problems, who generally show higher service use (OECD, 2012). Second, the data in the figure present exclusively MBS-rebated mental health services, while the survey was not restricted to this and as such probably resulted in a higher reporting rate of service use. Thus, on a positive side, the survey results imply better service use among young people with more severe problems. Nevertheless, the survey also showed that for 26% of youth with mental disorders, parents reported an unmet need for help and 39% reported that the need for help was only partially met (Lawrence et al., 2015).

The Commonwealth Government provides funding to community organisations for establishing Family Mental Health Support Services (FMHSSs). FMHSSs can use funds to invest in vulnerable families with children and young people up to age 18 who are exhibiting early signs of, or are at risk of developing, mental illness. Three different types of support are provided (Department of Social Services, 2013):

1. Intensive, long-term, early intervention services and whole-of-family assistance;
2. Short-term immediate assistance for families such as information provision and referral;
3. Community outreach and mental health education and activities.

Between 2007 and 2012, 54 FHMSSs provided individual support to around 80 000 children and young people up to the age of 24 (Department of Social Services, 2012). As the total number of under-24s was approximately 7.4 million in 2012, only about 1% of them were reached.

States and territories provide specialised Child and Adolescent Mental Health Services (CAMHSs) for young people under the age of 18 and their families. They primarily target those with more severe problems needing acute, intensive, and/or longer-term care. It is provided by multidisciplinary teams that bring together allied professionals like psychiatrists, clinical psychologists, social workers, and occupational physicians (Psychiatric Services Branch, 1996).

In addition to formal mental health services, young people may opt for self-management and use web-based, self-help programmes, for example. In 2006, the Australian Government introduced the Telephone Counselling, Self-Help and Web-based Support Programmes measure (Teleweb) to provide evidence-based telephone and online mental health programmes for

people with mild-to-moderate complaints who may not receive treatment or have trouble accessing face-to-face services.

A broad range of projects is available as part of Teleweb, with some specifically targeted at young people, such as *BITE BACK* and *Reach Out.com*. Both are interactive websites that offer information and support for improving mental health literacy and social and emotional skills (Department of Health, 2015). It remains questionable, however, whether young people actively avail themselves of e-mental health programmes. Under the government-funded ATAPS scheme, for example, the uptake of telephone-, video- and web-based mental health services by young people (aged 12 to 25) was found to be less than 1% (Bassilios et al., 2014).

Evaluation of the effect on treatment rates of the different services and programmes (Medicare-funded mental health services from GPs or other providers, FMHSS, CAMHS, Teleweb, etc.) is complicated by the different ways in which they are funded, implemented, and delivered. Clearly, only a small group of young people receive care from specialists.

It has been argued that 15 to 25 year-olds, who are changing from adolescence to early adulthood, seem particularly prone to falling into the cracks between the available mental health services. Indeed, services appear to be geared mostly towards adults or children with severe problems and/or from high-risk groups. They are ill-adjusted to the needs of adolescents and young adults, particularly those with mental health issues that have not yet reached the stage of a full-blown disorder (Purcell et al., 2011).

Low-threshold services for young people to increase treatment rates

To address young people's low uptake of mental health support, the Australian Government initiated *headspace*, the National Youth Mental Health Foundation, in 2006. With government funding, headspace centres have been set up to provide integrated, early intervention services for 12 to 25 year-olds with, or at risk of, mild-to-moderate mental illness (Box 3.4). As such, headspace can play a critical role in filling the gap between available mental health services for young people transitioning between adolescence and adulthood as described above. The centres are highly accessible, practising an open-door policy with no eligibility requirements.

Box 3.4. *Headspace* – easily accessible youth mental health support

Headspace addresses the mismatch between the need for and supply of mental health services among young people between 12 and 25 years old. The centres bring together a range of professionals – from psychologists, social workers, alcohol and other drug workers to GPs, career counsellors, vocational officers, and youth workers. *Headspace* centres are accessible, youth-friendly, integrated service hubs that provide evidence-based interventions and support to young people with mental health and wellbeing needs. Support covers four core areas of services – mental health, alcohol and other drugs, physical health, and social and vocational assistance – as part of the objective of providing holistic, integrated support. One essential aspect of that approach is young people's participation in their own health care and wellbeing management.

Headspace's access threshold is very low: anyone can walk in. The centres are thus ideally placed to reach young people with non-diagnosed common mental illness, or those at risk of developing mental illness. Services are provided largely free of charge or at a low cost and ensure high confidentiality. At July 2015, there were 83 headspace centres across Australia, a number that will be scaled up to 100 by 2016-17. *Headspace* works together with and refers to other services, such as government-funded employment schemes and the Department for Social Services (which assesses eligibility for income support and refers claimants to employment services). *Headspace* is also funded by the Australian Government to provide support service for secondary schools affected by suicide.

Headspace centres have been successful in reaching their targeted population. A recent study into 21 274 headspace clients, serviced between January and June 2013 (across all 55 centres open during this time), showed that almost 70% presented high or very high levels of psychological distress. About a third were assessed by clinicians as having a full-threshold or serious on-going disorder, or being in remission. The most common disorders were mood-related (28%), followed by anxiety (15%) and adjustment disorders (4%) Among almost 30%, no clinical diagnosis had been previously recorded – an indication of headspace's ability to reach out to the young with mental health problems who would otherwise not be identified (Rickwood et al., 2014).

Still, little information is available as to the effectiveness of headspace centres in reducing mental health problems and improving clients' social participation, especially in the long term. A recent study into the first 30 centres showed that only 7% worked to measure the effectiveness of their co-ordinated, integrated services and/or conducted clinical audits (Rickwood et al., 2015). Growing criticism has been levelled at headspace services in recent years. In addition to worries over large-scale implementation without sufficient evidence of effectiveness (Stark, 2013), concerns have been aired about headspace's "one size fits all" approach. It is acknowledged that there

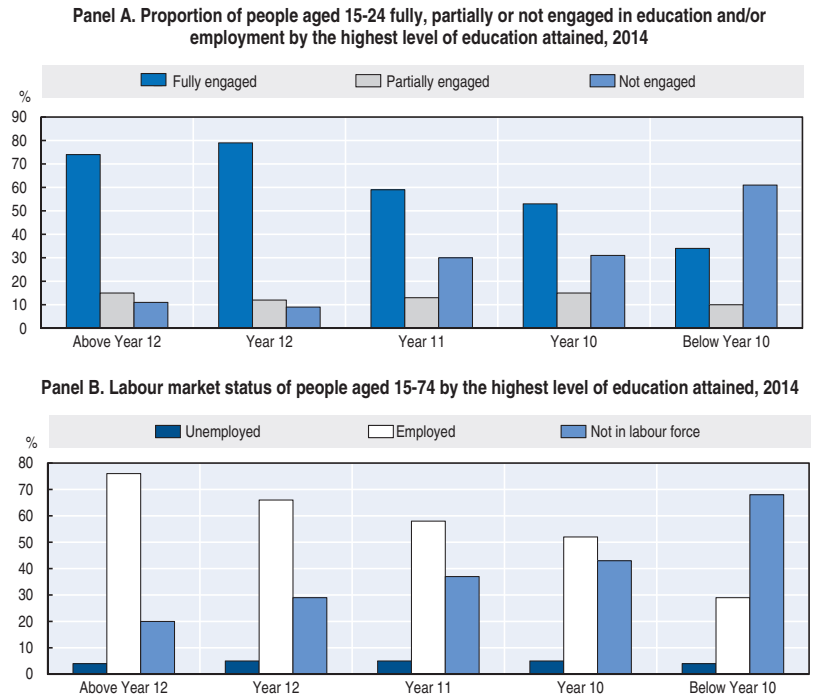
is significantly more work to be done in ensuring that centres are supported to adapt to the specific circumstances of local communities, rather than operating in a silo (National Mental Health Commission, 2014).

Put simply, while headspace centres are a promising effort to bring mental health services closer to young people, daunting challenges remain. Of special interest is whether it can fill the treatment gap for young people. In 2014, 50 149 young people received services in headspace centres. Nevertheless, higher uptake can be helpful only if the services prove effective in improving the mental health and social participation of young people. Future evaluations will have to address that concern.

Action to prevent early school leaving

Traditional pathways through education do not suit everyone. Tailored support and flexibly delivered education pathways are needed by young people who have disconnected from mainstream education or may be at risk of doing so. Early school leaving (ESL) – i.e. dropping out of school before completing at least secondary education – severely deteriorates labour market outcomes. Young people aged between 15 and 24 years old who have failed to reach Year 12 are three to six times more likely not to be engaged in education or employment (Figure 3.5, Panel A). The negative impact of ESL is, however, not restricted to the first years of young adulthood, but carries on through later adult life (Figure 3.5, Panel B).

Figure 3.5. **Labour market outcomes decrease drastically with lower levels of educational attainment**



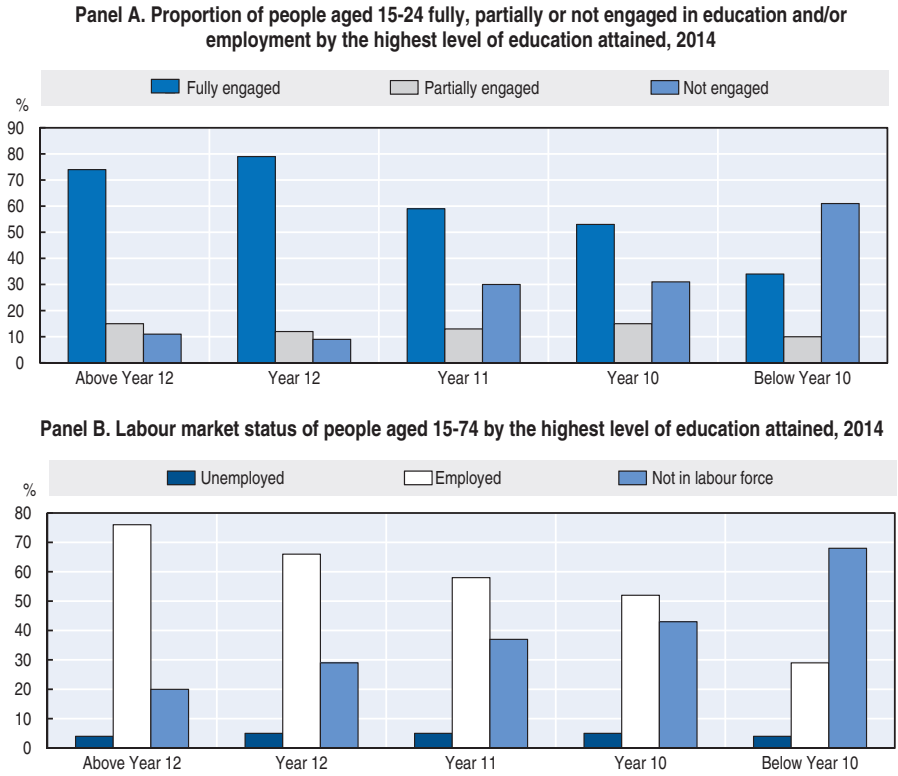
Source: Australian Bureau of Statistics, Education and Work Australia, May 2014.

StatLink http://dx.doi.org/10.1787/888933287605

Mental ill-health is an important risk factor in early school leaving

ESL is much more frequent among the young affected by poor mental health. On average, about 15% of young people with no such issues leave school early, compared to approximately 25% of their peers with moderate mental health problems and 27% of those with severe disorders (Figure 3.6, Panel A). One study has shown that even episodes of mental illness very early in life may affect ESL years later (Homlong et al., 2014): young people who were frequently seen by the mental health services were found to be over twice as likely to leave school early five years on. Moreover, Australian data show that pupils who suffer from mental health problems have poorer educational outcomes than their peers with other health problems (Figure 3.6, Panel B).

Figure 3.6. **Young people with poor mental health are more likely to leave school without a qualification**



Source: Panel A: OECD estimates based on Youth in Focus (Australia). Panel B: Likelihood of completing a VET qualification, 2008-11 (NCVER, 2014).

StatLink http://dx.doi.org/10.1787/888933287615

Appropriate responses to ESL require understanding why young people drop out. Data from the ABS survey of Disability, Vocation and Education Training (conducted in 2009) showed that reasons differed widely according to whether or not respondents suffered from a limitation or restriction. Among 15 to 24 year-olds with no disability, 35% responded that they did not complete Year 12 because they had found (or wanted) jobs or apprenticeships. That was twice the proportion compared to their peers with a restriction or limitation, whose most commonly cited reason for not completing Year 12 was ill health or disability (32% of responses). Such data on why young people with mental health problems drop out of school could help adjust ESL policy directed at them.

Insufficient efforts to tackle early school leaving

Australia has no structure for addressing ESL in a consistent way. Although school attendance is the duty of states and territories, they do not have a systematic approach to preventing ESL and rely on schools and local action to keep students in school or bring them back. Yet, while schools typically have systems for registering frequent or long-term absences and following up problematic cases, they have no information if a student changes schools and little power or tools to intervene should a student leave school early. Local initiatives are widespread, but often depend on short-term funding, which makes it difficult to supply consistent, integrated support to schools, young people at risk, and their parents (Lamb et al., 2004).

An additional drawback of short-term funding is the difficulty in finding and retaining skilled professionals for new programmes and service structures that may only run for two or three years (Department of Families, Housing, Community Services and Indigenous Affairs, 2011). The quality of service delivery may suffer as a consequence, especially when a funding arrangement comes to an end and highly skilled professionals choose to go and find other jobs. It may also undermine the development of strong relationships between young people and case managers (OECD, forthcoming).

An example of how a promising strategy to address ESL is not consistently and permanently implemented due to short-term funding is the National Partnership on Youth Attainment and Transitions.

Short-term funding curbs the work of the National Partnership on Youth Attainment and Transitions

In 2009, the Council of Australian Governments agreed to the National Partnership on Youth Attainment and Transitions, whose purpose was to improve educational outcomes and the transition to further education, training or employment of 15 to 24 year-olds. At the heart of the agreement were five programmes (Box 3.5).

Box 3.5. **The five agreements in the National Partnership on Youth Attainment and Transitions**

- ***Maximising Engagement, Attainment and Successful Transitions (MEAST)*** provided funded states and territories for activities in the areas of multiple learning pathways (e.g. designing a comprehensive curriculum with multiple, flexible learning options), career development, and mentoring.
- ***School Business Community Partnership Brokers*** – a programme for building partnerships between education, business, families, and the community to support young people in educational attainment.
- ***Youth Connections*** was developed as a safety net for young people who had dropped out of education or were at risk of doing so. Individually-tailored case management and support was provided to help young people re-connect with education or training and build resilience, skills and attributes that promote positive life choices and wellbeing.
- ***National Career Development*** commenced only shortly before the end of the National Partnership, in May 2013. It sought chiefly to raise stakeholders' awareness of the importance of career development for the labour market outcomes of young people and to secure their recognition that it was a policy priority.
- ***The Compact with Young Australians*** promoted skills acquisition and educational attainment through:
  - The National Youth Participation Requirement which requires all young people to participate in education, training or employment until the age of 17;
  - Entitlement to an education or training place for 15 to 24 year-olds; and
  - Stricter participation requirements for certain types of income support, particularly young people under the age of 21 without a Year 12 or equivalent qualification who applied for income support through Youth Allowance. They were required to participate in education or training. A similar requirement applied to young people aged 16 to 20 whose families claimed family tax benefit.

With the National Partnership, the Australian Government clearly addressed the importance of preventing ESL. A final evaluation conducted in 2013 showed that, nationwide, it appeared to improve the educational outcomes of students aged 15 to 19 years old (although it is impossible to say there was a cause-effect relationship between the Partnership and improvement observed). Specifically, the rate of participation in full-time education rose between 2009 and 2013 from 69.5% to 75.9%, whereas it had been relatively stable until 2009 (Dandelopartners et al., 2014).

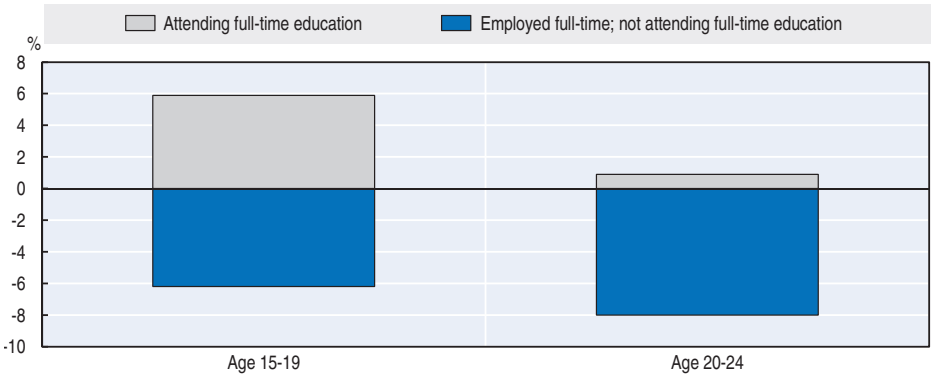
As funding for the National Partnership programmes stopped after 2014, many of the schemes developed under its aegis are left without the means to continue. It is not clear how some of the seemingly successful ones, such as Youth Connections, will be followed up or grounded in existing, more permanent service structures.

With the new 2015-16 budget, funding to address early school leaving and improve educational attainment was reduced. Before, the National Partnership had provided AUD 288 million for Youth Connections and AUD 183 million for School Business Community Partnership Brokers (both for four years). Compared to this, the new budget has allocated AUD 212 million (also over four years) for the Youth Transition to Work programme which will entail intensive support services provided by community-based organisations for early school leavers between the ages of 15 and 21, and AUD 13.5 million for "earn or learn" requirements. To be precise, from January 2016 all early school leavers will be required to actively look for work if they are not in full-time education or a combination of education and part-time work of 25 hours per week. Early school leavers will also be required to meet their activity requirements of 25 hours per week until they turn 22 or have achieved a Year 12 or Certificate III qualification (Parliament of Australia, 2015). How community-based organisations will provide support for early school leavers under the Youth Transition to Work programme – along the principles of the Youth Connections programme, for example – remains unclear.

The National Partnership was not an unmitigated success story. It had scant results in getting 20 to 24 year-olds into education. Their employment rate dropped by a significant 8% between 2008 and 2013, but was not offset by a comparable rise in participation in full-time education (which increased only 0.9%). Inactivity among young adults is thus growing (Figure 3.7). The trend is clearly reflected in the fact that the proportion of NEETs has risen considerably since the global financial crisis, especially among 20 to 24 year-olds – even though, at 14%, it was still below the OECD average of 18% in 2013 (OECD, 2015).

Figure 3.7. **Participation in full-time employment or education among young adults has fallen**

Changes in the percentage of 15 to 24 year-olds employed full-time or attending full-time education between 2008 and 2013

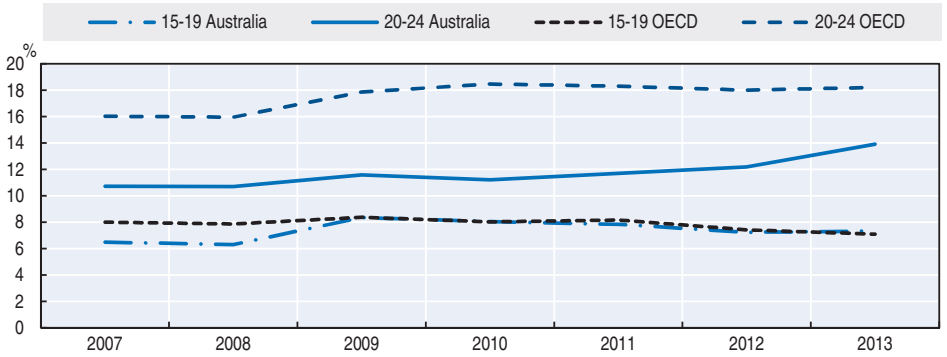


Source: Dandelopartners et al. (2014), "Evaluation of the National Partnership on Youth Attainment and Transitions: A Report for the Department of Education", Dandelopartners, Melbourne.

StatLink http://dx.doi.org/10.1787/888933287622

Figure 3.8. **NEET rates have risen since the global financial crisis**

Youth not in employment, education or training (NEET), as percentage of the same age group, 2007-13



Source: *OECD Education Database.*

StatLink http://dx.doi.org/10.1787/888933287632

No provision for tracking early school leavers

There is still no investment in a coherent structure for registering and monitoring early school leavers. Only the few young people, up to 22 years, receiving youth unemployment benefits are followed up by an employment

service provider and have a participation requirement in education or training until they attain Year 12 or an equivalent qualification. The Dutch and Danish systems might inspire future efforts in Australia when it comes to addressing all ESLs, not only the few who receive unemployment benefits. The Netherlands has introduced a national ESL system that compels schools to register their students who have left school early. The national register is also used to monitor and benchmark schools' performances in preventing ESL. Those that manage to keep it below nationally set levels receive extra funding to further invest in their students (OECD, 2014a).

Denmark has gone even further with its Municipal Youth Guidance Centres. They are responsible for monitoring all young people's transition from lower to upper secondary school and for following up on those who drop out of school (Box 3.6). Australia might be able to develop a structure with a comparable role in registering, monitoring, and managing ESL.

Box 3.6. **Preventing and managing early school leaving in Denmark**

Denmark introduced its Municipal Youth Guidance Centres to:

- Counsel young people up to the age of 25 in their critical transition from lower- to upper-secondary education and employment,
- Follow up on those who drop out of upper-secondary education.

Guidance counsellors are responsible for preparing education plans for all pupils to ensure a smooth transition into upper secondary education and employment. Planning involves meetings between counsellors, pupils and parents. It builds on pupils' school records, which provide information on their achievements, interests, expectations for the future, and how they wish to develop.

The transition process between lower and upper secondary education is monitored and pupils between 15 and 17 years old who fail to turn up for upper secondary education after compulsory schooling ends are monitored to prevent them from leaving early. In the event of a pupil's non-attendance, the guidance counsellor has to get in touch with the parents within five days of being notified by the school and initiate action within 30 days. Counsellors are not allowed to provide any treatment or therapy but they can identify problems and refer pupils or parents to specialists – a social worker for family problems, for example, or a psychologist in the event of mental illness.

The centres co-operate closely with educational institutions and the municipal job centres, many of whose clients are young people, particularly 18 to 19 year-olds, as they widely seek guidance from job centres on labour market questions and employment options. The guidance centres have access to a database with full overviews of the education and training of all under-25s in the municipality who have not completed upper secondary education. The system enables the centres to spot vulnerable young people at a glance.

Source: OECD (2012), *Mental Health and Work: Denmark*, OECD Publishing, Paris.

Optimising the transition from school to work

Compared to most OECD countries, young people in Australia have relatively good employment outcomes. Even when at school and in further education, many students have jobs – more so than in other OECD countries, in fact. In 2012, 63% of young Australians combined work and study, while the average OECD figure was 40% (OECD, 2014b). Such early work experience can greatly help the school-to-work transition. Possibly related to the high numbers of students who work are Australia's youth unemployment rates, which are lower than in the average OECD country – 13.3% compared to 15.0% in 2014 (*OECD Employment Database*, www.oecd.org/employment/database, accessed 2 September 2015).

Nevertheless, since the global financial crisis (GFC), young adults' employment outcomes have worsened. From 8.8% in 2008, the unemployment rate of 15 to 24 year-olds not in education has steadily risen to reach 12.2% in 2013, while youth unemployment is more than twice as high as among adults – e.g. 5.4% for 25-34 year-olds and 4.8% among people between 35 and 44 (*OECD Employment Database*).

Other youth employment outcomes show a similar trend. For example, the share of university and VET students who find jobs after graduation dropped by 10 to 15 percentage points between 2008 and 2012 (Stanwick et al., 2013).

The National Partnership on Youth Transitions and Attainment, had little success in improving school-to-work transitions. In fact, this transition has only become more difficult. The percentage of young people who are unemployed and looking for their first full-time job rose between 2009 and 2012 by 8% among 15 to 19 year-olds and 14% among 20 to 24 year-olds, although there was a drop between 2012 and 2013 (Dandelopartners et al., 2014). Furthermore, as pointed out above, the increase in NEETs and youth unemployment also indicate that young people are struggling increasingly to get into work.

The 2015-16 budget has allotted little funding to addressing the current school-to-work transition problems of young people in general – aside from the focus on early school leavers and severely disengaged youth. The provision of transition support before young people leave educational institutions is missing. However, the National Work Experience Programme, which receives AUD 18.3 million over five years, might contribute to some extent. It supports unpaid work experience of up to 25 hours per week for up to four weeks (Parliament of Australia, 2015).

Supporting the school-to-work transition among young people with mental health problems

The difficulties of the labour market situation for young people are even more pronounced among those with mental health problems. Research has consistently shown that people with mental disorders are less likely to be employed and more likely to be unemployed (OECD, 2012). Data from the Australian Bureau of Statistics confirm that picture and even show that jobseekers with psychological disabilities have less chance of finding work than their peers with other disabilities (ABS, 2012). One reason may be that fewer young people with mental health problems go on to higher education, so losing the prospect of a successful transition into work (OECD, 2015).

While school-to-work support services have not been institutionalised within schools or youth services on a national scale, there is rising awareness that more needs to be done – especially for more disadvantaged young people, including those with mental health problems. Accordingly, some promising projects have been developed. Examples are the Beacon Community Core Model, a number of programmes from national youth service and advocacy organisation *BoysTown* and, specifically for the young with mental health problems, *Orygen Youth Health* (Box 3.7). Also, as discussed in Chapter 2, the Commonwealth Government has provided funding to implement a national trial, from 2015 to 2019, on Individual Placement and Support for young people with mental illness up to age 25. Next to that, Youth Disability Transition Programs are offered to youths with recognised, profound disability – which will thus only reach out to a very small group with severe mental illness – to help them transition from secondary education to employment and/or further education.

While evaluations of such programmes generally remain restricted to before-after measurements with no control groups, the data suggest that they have been successful in helping young people to lengthen their schooling and transition smoothly to work. A common element is that they all build on collaborative networks between schools, employers and youth services.

Box 3.7. **Promising examples of school-to-work transition support**

The Beacon Model

The Beacon Foundation is a not-for-profit organisation founded in 2008 that seeks to smooth young people's transition from school to work. The Beacon Model is a holistic approach that brings together schools, the community and local businesses as part of a long-term sustainable method of addressing youth unemployment. It operates over a three-year period during which Beacon helps the key players to work together and prepare young people for work.

Box 3.7. **Promising examples of school-to-work transition support** *(cont.)*

The Beacon Foundation also provides one-day Work Readiness programmes for schoolchildren between 7 and 12 years old. Beacon's 2013 annual report notes that it has worked with 132 schools in Australia and that the schools where Beacon operates have higher retention, employment and participation rates than the national average. Over 98% of students supported by Beacon were fully engaged in work, education or training nine months after completing Year 10 – 11.6% higher than the national average for 16 to 17 year-olds from underprivileged socio-economic backgrounds.

***BoysTown*'s school-to-work transition programmes**

BoysTown is a national youth service and advocacy organisation and registered charity with over 50 years of experience in working with disadvantaged young people. It has developed school-to-work transition programmes in which it closely collaborates with such local stakeholders such as mental health services, schools, and technical and further education (TAFE) and employment service providers.

BoysTown's intervention model is multidimensional, helping young people to overcome barriers to engagement and to re-engage in learning and working. Interventions include: individual case management, psychological assessment, and training in interpersonal skills, basic life-skills, literacy and numeracy, employability skills (including industry visits), and job seeking. From 2004 to 2012, the intervention model was evaluated in Queensland with positive findings: 50% of programme participants entered employment, 20% resumed education, and 20% commenced accredited training.

BoysTown has run a number of other pilot projects to trial its intervention model in different contexts. For example, it piloted the programme "Project Job Ready" in 2012 in collaboration with the Brisbane Metro Region of Education Queensland. In the pilot, local Youth Connections staff worked with school support staff to case-manage 50 students whom schools deemed to be at high risk of not transitioning to full-time work. Of the 45 Year 12 students who took part, 40% reported engagement and retention in either full-time education or training more than six months after completion of formal schooling. Of the remaining group still connected to *BoysTown*, 13% were in part-time work, 9% in casual employment or seeking employment, and 20% receiving additional support from a *BoysTown* youth worker. Of the remaining 18% no data were available (BoysTown, 2013).

***Orygen Youth Health*: Employment services alongside mental health services**

Orygen Youth Health is a state-funded, hospital-based youth mental health service running an experimental Psychosocial Recovery programmes in the form of Individual Placement and Support (IPS) for young people. Employment counsellors are directly employed by the health service and provide support in attaining educational goals or finding and maintaining employment in line with the IPS model for adults.

Orygen focuses on first-episode psychoses, mood disorders, and personality disorders. Nevertheless, it does not require young people to have been diagnosed and strongly focuses on early prevention when first signs of mental illness arise. Referrals may thus also come from schools, families, and the community.

Box 3.7. **Promising examples of school-to-work transition support** *(cont.)*

The main goal of Psychosocial Recovery is to help young people return to school, training, or employment. They can work on job interviews, update their resume, explore their skills, and identify training needs. *Orygen* offers a Psychosocial Recovery Group Program as a first step in vocational recovery. It provides structure, routine, and opportunities to participate in meaningful activities with others. Qualified teachers on-site support young people in staying at or returning to school. Those who are ready to enter the workplace enjoy access to employment consultants from outside agencies and advisors employed at *Orygen*.

An evaluation of the effectiveness of the Psychosocial Recovery Group Program for young people with first-episode psychosis is currently being undertaken in a randomised controlled trial (Killackey et al., 2013). Initial – though not yet published – results are positive. The integrated approach of the Group Program is more effective than health intervention alone – 85% of the participants went on into education or employment compared to 29% in the control group. Factors that contribute to the success of *Orygen* include the low caseload of 20 clients and the focus on prevention and early intervention (before clients are caught in the web of inactivity).

Sources: Beacon Foundation (2013), Annual Outcomes Report Released 2013, Beacon Foundation, Hobart; BoysTown (2013), Response to Department of Education Employment and Workplace Relations issues paper: Employment services: Building on Success, BoysTown, Milton; Department of Social Services (2015), *A new system for better employment and social outcomes – Interim report of the reference group on welfare reform to the Minister for Social Services*, Commonwealth of Australia, Canberra; OECD (2015), *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work,* OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264228283-en; The Beacon Foundation (2015), http://beaconfoundation.com.au (accessed 2 September 2015).

Support structures in the school system and youth services that facilitate the school-to-work transition are extremely important for two reasons:

1. Few unemployed (young) people are eligible to use employment services (see Chapter 5) so cannot rely on its support in the transition to the workplace.
2. School and youth service structures can intervene at the very beginning of the transition process – while the young are still in education and before they fall into the cracks between education and employment.

Young people with mental health problems have not been a particular target group in government support for school-to-work transition in the past. A recent initiative has changed that. From 2015-16, the government is to provide AUD 105.7 million over five years to improve the employment, educational and social outcomes of vulnerable young jobseekers at risk of long-term unemployment. Among them young people with mental health problems are a specific target group. Part of the funding (AUD 19.4 million) will be directed at two new trials:

1. The national, four-year IPS trial to improve employment outcomes for young people up to age 25 with mental illness, mentioned above and in Chapter 2;

2. A one-year trial to test a participant-driven employment assistance model on young participants in Disability Employment Services (DES) with mental illness. The trial is available for up to 200 eligible DES participants who are 24 years old or under and will inform future employment services for people with disability from 2018. The trial is being supplemented with an evaluation and additional youth mental health training and support for all DES providers (Parliament of Australia, 2015).

It will be important to monitor whether the new trials manage to reach out to young people with mental ill-health and improve their employment outcomes. In that regard, the question arises as to whether expenditure on new trials is preferable to support for existing programmes (like those described Box 3.7) which have built considerable experience, boast some success, and operate on a larger scale.

That it is a struggle for young people – particularly for those, like the ones with mental health problems, who are disadvantaged – to make the transition from school to work has become evident. Yet a good support system has yet to be developed. Schools (ideally placed to spot pupils who struggle to transition), employment services (which have employment support expertise), youth services (with their case management skills), and employers (who can provide work experience) should make it their joint responsibility. Some promising projects that build on such a shared effort are in place. However, they only have funding and capacity to support small groups of young people.

Round-up and recommendations

The Australian Governments and community in general clearly acknowledge the importance of fostering mental wellbeing among children and young people. Accordingly, there has been strong investment in school mental health promotion programmes which appears to have improved mental health literacy as well as wellbeing. However, there is no coherent system in place within schools for early action upon young people who suffer from mental health problems. Specifically speaking, in-school mental health services that are closely connected to specialised mental health care providers are needed.

Headspace centres have helped improve the mental health service provision for young people. Headspace's low access threshold and close

connectedness with other health and community services are crucial factors, given that the young are widely reluctant to disclose mental health issues or to access services of their own accord. However, a priority should be to monitor headspace's mental health and social participation outcomes among the young people. Furthermore, it remains to be seen whether headspace will develop a nationwide capacity to cater for all young people with mental health problems in need of support.

Australia's greatest challenge when it comes to good employment outcomes for young people with mental health problems is to build a nationally coherent support structure to take action on early school leaving. Currently, only local initiatives are available to help early leavers back to school or into work. However, it is not a given that such initiatives are in place or that there will be enough funding to keep them in existence. Moreover, if schools do not refer their early school leavers to local services, chances are slim that young people find their own way to them. Without a system that monitors early school leaving and registers when and why young people drop out from school, it will always be a struggle to respond promptly and develop appropriate policies.

Related to the challenge of early school leaving is that of school-to-work transition programmes. Although transition support before young people leave school and slip into inactivity is crucial, no policies address the need. Yet successful school-to-work programmes – involving schools, youth services, and employers – exist that could well feed government efforts to improve school-to-work transitions.

Altogether, Australia has a large array of promising projects that seek to improve mental health and employment outcomes for young people. However, there are two recurrent problems: the lack of thorough programme evaluation and inadequate short-term funding. As a consequence, few projects are incorporated in national policies or result in large-scale roll-outs.

Improve school-based mental health services

- *Evaluate mental health services within schools.* Schools are free to decide whether and how they want to provide mental health services. As many young people seek support within the school environment, such services play an important role in providing first-time support when mental health issues occur. However, no data are available on how many schools have, for example, a child psychologist or social worker, or how many students with mental health issues are supported by school services. Such information is essential to assessing whether schools are

filling a gap in youth mental health support, or whether policies are needed to further strengthen such support.

- *Develop mental health support structures within tertiary education.* While mental health promotion within primary and secondary education has been the focus of much attention, the mental health and wellbeing of tertiary students has not. As these are students who transition to work, mental health problems may directly impact employment opportunities. Given students' unwillingness to disclose any mental health concerns, a universal approach – along the lines of *KidsMatter* and *MindMatters* in primary and secondary education – could be an appropriate approach for tertiary students.

Develop a coherent policy for early school leaving

- *Create a system for monitoring early school leaving.* Leaving the monitoring of early school leaving to schools has several disadvantages:
  - Not all schools may choose to monitor early leavers.
  - Children who change schools are lost track of.
  - Schools develop their own systems, which is inefficient.
  - There is no guarantee there will be any direct linkage between early school leaving registers and support services.

A registration system at the state or territory level could overcome such disadvantages and, if made accessible to support services, could prompt quick action on early school leaving. A state or territory system would allow the benchmarking of schools' efforts to reduce early school leaving.

- *Implement a permanent structure to support young people disengaged from education and work.* Youth Connections was a first large-scale effort to case-manage early school leavers, but has not resulted in any durable national structure despite its positive results. It remains unclear whether the new Youth Transition to Work programme will build upon Youth Connections. Bringing back the Youth Connections structure should be a top priority to ensure that young people who drop out of education have a visible, easy accessible place to which they can turn. Linking such a service with a state- or territory-level early school leaving registration system would be a highly desirable mechanism for swiftly monitoring and contacting school drop-outs.

Offer school-to-work transition support early on

- *Provide holistic school-to-work transition support for secondary and tertiary school students.* Growing rates of youth unemployment and young people not in employment, education or training warrant firm policy to support the transition into work. Action should start when young people are still in school where they can be easily reached. Employment consultants, for example, could be drafted into schools. Employability skills and job search training could also be provided, ideally in co-operation with employment service providers (Chapter 5). But responsibility extends beyond the school system. Especially when it comes to young people with mental health issues, there must be close collaboration with youth services if non-vocational barriers to employment are to be overcome.
- *Make use of existing transition support programmes.* The Australian Government can build on several community initiatives to trial programmes designed to help young people make the school-to-work transition. Instead of directing all funding for transition support into new trials, though, more use could be made of existing programmes that have proven effective. One course of action could be to evaluate how to implement such programmes on a larger scale, or at least which programme components to use in developing a national school-to-work transition service.
- *Register students at risk of early school leaving with employment service providers.* In line with recommendations by the youth advocacy organisation *BoysTown*, teachers and other service providers who work with students at risk of becoming disengaged from education and employment should be able to register those students with an employment service provider. The provider could then develop an action plan to support the transition to further education or employment, along the lines of what Denmark's Municipal Youth Guidance Centres do.

Notes

1. Pastoral care is the practice of looking after the personal needs of students, not just their academic needs, through the provision of general spiritual and personal advice.
2. www.mindmatters.edu.au (accessed 2 September 2015).

References

ABS – Australian Bureau of Statistics (2013), "6291.0.55.001 Labour Force Australia", Detailed, Electronic Delivery Aug 2013, Australian Bureau of Statistics, www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6291.0.55.001Aug%202013?OpenDocument (accessed 18 June 2015).

ABS (2012), "4102.0 Australian Social Trends", March Quarter 2012, Australian Bureau of Statistics, www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features40March+Quarter+2012#lfp (accessed 18 June 2015).

ABS (2009), "44290DO006_2009 Disability, Ageing and Carers, Australia 2009", Profiles of Disability, Australia, Table 8.

ABS (2008), "National Survey of Mental Health and Wellbeing: Summary of Results, 2007", ABS, Canberra.

Bassilios, B. et al. (2014), "Uptake of a National Primary Mental Health Program by Young People in Australia", *International Journal of Mental Health Systems*, Vol. 8, No. 10, pp. 1-5.

Beacon Foundation (2015), http://beaconfoundation.com.au (accessed 18 June 2015).

Begg, S. et al. (2007), *The Burden of Disease and Injury in Australia 2003*, Australian Institute of Health and Welfare, Canberra.

BoysTown (2013), *Response to Department of Education Employment and Workplace Relations issues paper – Employment Services: Building on Success*, BoysTown, Brisbane.

Campbell, M. and S. Colmar (2014), "Current Status and Future Trends of School Counselling in Australia, *Journal of Asia Pacific Counselling*, Vol. 4, No. 3, pp. 181-197.

Cvetkovski, S., N. Reavley and A. Jorm (2012), "The Prevalence and Correlates of Psychological Distress in Australian Tertiary Students Compared to their Community Peers", *Australian and New Zealand Journal of Psychiatry*, Vol. 46, No. 5, pp. 457-467.

Dandelopartners et al. (2014), *Evaluation of the National Partnership on Youth Attainment and Transitions: A Report for the Department of Education*, Dandelopartners, Melbourne.

Department of Families, Housing, Community Services and Indigenous Affairs (2011), *Working with Australians to Promote Mental Health, Prevent Mental Illness and Support Recovery: Evaluation of the FaHCSIA Targeted Community Care Mental Health Initiatives*, Final Report, Commonwealth of Australia, Canberra.

Department of Health (2015), "Teleweb", website pages on Teleweb, www.health.gov.au/internet/main/publishing.nsf/Content/mental-teleweb (accessed 27 February 2015).

Department of Health and Ageing (2013), *National Mental Health Report 2013: Tracking Progress of Mental Health Reform in Australia 1993-2011*, Commonwealth of Australia, Canberra.

Department of Social Services (2015), *A New System for Better Employment and Social Outcomes – Interim Report of the Reference Group on Welfare Reform to the Minister for Social Services*, Commonwealth of Australia, Canberra.

Department of Social Services (2013), *Part C3: Family Mental Health Support Services activity Guidelines under the Targeted Community Care (Mental Health) Program*, Commonwealth of Australia, Canberra.

Department of Social Services (2012), *Targeted Community Care (Mental Health) Program – Family Mental Health Support Service Fact Sheet*, Commonwealth of Australia, Canberra.

Fildes, J. et al. (2014), *Mission Australia's 2014 Youth Survey Report*, Mission Australia.

Homlong, L., E. Rosvold and O. Haavet (2013), "Can Use of Healthcare Services Among 15-16 Year-olds Predict an Increased Level of High School Dropout? A Longitudinal Community Study", *BMJ Open*, Vol. 3., No. 9, p. e003125.

Hunter Institute of Mental Health and Community Services & Health Industry Skills Council (2012), *Children's Mental Health and Wellbeing: Exploring Competencies for the Early Childhood Education and Care Workforce*, Final Report, Department of Education, Employment and Workplace Relations, Commonwealth of Australia, Canberra.

Ivancic, L. et al. (2014), "Youth Mental Health Report June 2014", Mission Australia and Black Dog Institute, June.

Kessler, R. et al. (2005), "Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication", *Archives of General Psychiatry*, No. 62, pp. 593-603.

Killackey, E. et al. (2013), "A Randomized Controlled Trial of Vocational Intervention for Young People with First-episode Psychosis: Method", *Early Intervention in Psychiatry*, Vol. 7, No. 3, pp. 329-337.

Lamb, S. et al. (2004), "Staying on at School: Improving Student Retention in Australia", Centre for Post-compulsory Education and Lifelong Learning, University of Melbourne, Melbourne.

Lawrence, D. et al. (2015), *The Mental Health of Children and Adolescents. Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing*, Department of Health, Commonwealth of Australia, Canberra.

Ministry of Education, Science and Training (2006), *Disability Standards for Education 2005 plus Guidance Notes*, Commonwealth of Australia, Canberra.

Muir, K. et al. (2009), *State of Australia's Young People: A Report on the Social, Economic, Health and Family Lives of Young People*, Office for Youth, DEEWR, Social Policy Research Centre, University of New South Wales, Sydney.

National Mental Health Commission (2014), *The National Review of Mental Health Programmes and Services*, National Mental Health Commission, Sydney.

NCVER – National Centre for Vocational Education Research (2014), *Australian Vocational Education and Training Statistics: the Likelihood of Completing a VET Qualification, 2009-12*, National Centre for Vocational Education Research, Adelaide.

Neil, A. and H. Christensen (2007), "Australian School-based Prevention and Early Intervention Programs for Anxiety and Depression: A Systematic Review", *Medical Journal of Australia*, Vol. 186, No. 6, pp. 305-308.

OECD (forthcoming), *Investing in Youth – Australia*, OECD Publishing, Paris.

OECD (2015), *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264228283-en.

OECD (2014a), *Mental Health and Work: Netherlands*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264223301-en.

OECD (2014b), *OECD Employment Outlook 2014,* OECD Publishing, Paris, http://dx.doi.org/10.1787/empl_outlook-2014-en.

OECD (2012), *Sick on the Job? Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264124523-en.

Parliament of Australia (2015), website of the Parliament of Australia www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201516/Workforce (accessed 17 June 2015).

Psychiatric Services Branch (1996), *Victoria's Mental Health Service: The Framework for Service Delivery – Child and Adolescent Services*, Victorian Government Department of Health and Community Services, Melbourne.

Purcell, R. et al. (2011), "Toward a Twenty-first Century Approach to Youth Mental Health Care", *International Journal of Mental Health*, Vol. 40, No. 2, pp. 72-87.

Reavley, N., T. McCann and A. Jorm (2012a), "Actions Taken to Deal with Mental Health Problems in Australian Higher Education Students", *Early Intervention in Psychiatry*, Vol. 6, No. 2, pp. 159-165.

Reavley, N., T. McCann and A. Jorm (2012b), "Mental Health Literacy in Higher Education Students", *Early Intervention in Psychiatry*, Vol. 6, No. 1, pp. 45-52.

Rickwood, D., N. Van Dyke and N. Telford (2015), "Innovation in Youth Mental Health Services in Australia: Common Characteristics across the First Headspace Centres", *Early Intervention in Psychiatry*, Vol. 9, No. 1, pp. 29-37.

Rickwood, D. et al. (2014), "Headspace – Australia's Innovation in Youth Mental Health: Who Are the Clients and Why Are They Presenting?", *Medical Journal of Australia*, Vol. 200, No. 2, pp. 1-4.

Slee, P. et al. (2012), *KidsMatter Early Childhood Evaluation Report*, Shannon Research Press, Adelaide.

Slee, P. et al. (2009), *KidsMatter Primary Evaluation Final Report*, Centre for Analysis of Educational Futures, Flinders University of South Australia, Adelaide.

Stanwick, J. et al. (2013), *How Young People Are Faring 2013, National Report on the Learning and Earning of Young Australians*, Foundation for Young Australians, Melbourne.

Stark, J. (2013), "Debate Surrounds the Headspace Model of Mental Health Services", *The Sydney Morning Herald*, 10 November. www.smh.com.au/national/debate-surrounds-the-headspace-model-of-mental-health-services-20131109-2x8lf.html (accessed 2 September 2015).

Urbis (2011), *Literature Review on Meeting the Psychological and Emotional Wellbeing Needs of Children and Young People: Models of Effective Practice in Educational Settings*, Final report prepared for the Department of Education and Communities, Urbis.

Venville, A. and A. Street (2012), "Unfinished Business: Student Perspectives on Disclosure of Mental Illness and Success in VET", National Centre for Vocational Education Research, Adelaide.

Wyn, J. et al. (2000), "MindMatters, A Whole-school Approach Promoting Mental Health and Wellbeing", *Australian and New Zealand Journal of Psychiatry*, Vol. 34, pp. 594-601.

Database references

OECD Education Database, https://data.oecd.org/youthinac/youth-not-in-education-or-employment-neet.htm.

OECD Employment Database, www.oecd.org/employment/database.

Chapter 4

Workplace mental health support in Australia

This chapter evaluates the extent to which the Australian workplace contributes to good mental health and offers a supportive environment to those people who are confronted with mental health problems. It looks at the relationship between working conditions, mental health and productivity and then considers policies to prevent psychosocial risks at work, to promote mental health, and to support workers with mental disorders. The chapter ends with a review of sickness management and return-to-work strategies, and particularly the roles of employers, governments, and general practitioners.

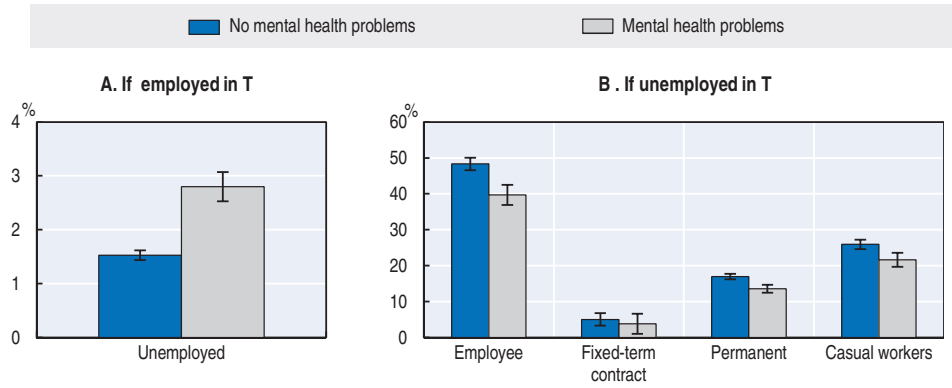
Most people who suffer from mental health problems are in work (OECD, 2012). Employers and the workplace are thus central to mental health and work policies. And because there is clear evidence that being in work improves mental health (OECD, 2012), the workplace is the ideal setting for fostering good mental health and well-being and for preventing psychological harm. Workplaces also afford opportunities for responding early when mental health issues arise to ensure that employees remain in work and avoid long spells of sick leave.

Working conditions and mental health

As work is important for good mental health, policy should seek to help people stay in employment or find work quickly when they lose their job. This is particularly important for people with mental health problems as data show that they are about twice as prone to unemployment as their healthier peers and, when jobless, are 20% less likely to return to the workplace (Figure 4.1).

Figure 4.1. **The prospects of finding work after job loss are poorer for workers with mental health problems**

Employment status at time T+1 for employed and unemployed people at time T, by mental health status



Source: OECD calculations based on the Household, Income and Labour Dynamics in Australia survey.

StatLink http://dx.doi.org/10.1787/888933287642

Research has shown that estrangement from the workplace diminishes mental wellbeing, while resuming work improves it (Thomas, Benzeval and Stansfeld; 2007). People value work not only for the monetary benefits it brings, but also because it meets their desire to contribute to society. It can

also give a sense of accomplishment and belonging and strengthens social lives (Saunders and Nedelec, 2014).

Conversely, however, poor working conditions can significantly contribute to the emergence of mental health problems. A review of available longitudinal studies on work-related factors that influenced mental health found that some – such as job strain (i.e. psychologically demanding work with limited decision-making latitude), poor social support from co-workers, and high job insecurity – were predictors of mental health issues (Stansfeld and Candy, 2006).

Studies have also confirmed the relationship between working conditions and mental health in Australia. One such study, which drew on a cohort of 1 286 Australians aged between 32 and 36, found that perceptions of unfair pay, low levels of support from colleagues and managers, and unfair treatment significantly increased the risk of depression (Butterworth et al., 2013). Low job security, too, was related to depression among those employees who said that they worked for material reasons (as opposed to personal fulfilment, for example).

The strongest case for good workplace conditions may have been made by an Australian study showing that a poor job is no better, or even worse, for mental health than no job at all (Butterworth et al., 2011). And, although work has generally been found to be good for mental health, the study – which drew on the Household, Income and Labour Dynamics in Australia (HILDA) survey – found that:

- Workers with the poorest psychosocial job quality (i.e. highly demanding and complex tasks, low job control, high insecurity, and unfair pay) had mental health which was comparable to or worse than those who were unemployed.
- The mental health of workers in the poorest-quality jobs declined faster over time than that of the unemployed.
- Finding a poor quality job was more detrimental to mental health than remaining unemployed.

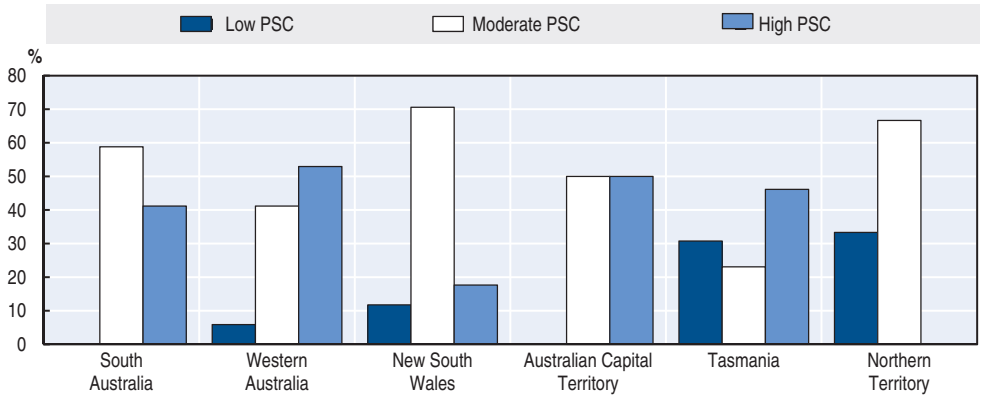
Employee job strain in Australia

An interesting insight into psychosocial risk levels in Australian workplaces was afforded by research from the University of South Australia (Dollard et al., 2012). Drawing on 5 743 interviews with employees across six Australian states, the researchers collected information on, among other things, the psychosocial safety climate (PSC), job strain, and mental health. They found that PSC predicted job strain and mental health.

The researchers than drew up PSC cut-off scores to classify 17 broad industries (e.g. education, construction, health and community services) by low, moderate or high risk of employee job strain and mental ill-health (Figure 4.2). While there were differences between states and territories, the overall conclusion was that PSC in most industries is moderate – in other words, the risk of job strain and mental ill-health among workers is also moderate.

Figure 4.2. **Most industries in Australia have a moderate psychosocial climate**

Share of industries with a low, moderate or high psychosocial climate (PSC), by state and territory



Note: In Australian Capital Territory only six of the 17 industry groups could be included and in Northern Territory three, due to the low number of participants.

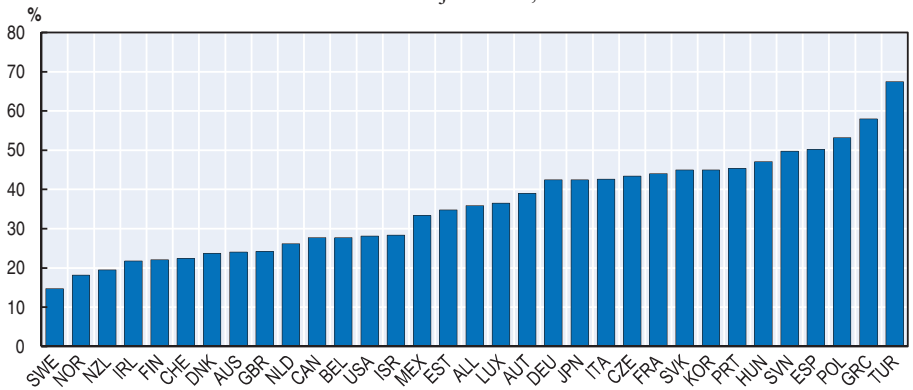
Source: Dollard, M. et al. (2012), *The Australian Workplace Barometer: Report in Psychosocial Safety Climate and Worker Health in Australia*, University of South Australia, Magill.

StatLink http://dx.doi.org/10.1787/888933287658

Internationally, Australia seems to do relatively well with regard to quality of work. OECD (2014a) finds that relatively few employees report experiencing job strain. It ranks fifth out of 32 countries for incidence of excessive job demands and eighth for insufficient resources – with the highest ranking denoting the lowest incidence of excessive demands and insufficient resources. Nevertheless, one in four employees in Australia does report job strain (Figure 4.3).

Figure 4.3. **Australians experience relatively low job strain**

Incidence of job strain,[a] 2005



Note: The European Working Conditions Survey (EWCS) was used to calculate the incidence of job strain for all European countries and the International Social Survey Programme (ISSP) for all non-European countries.

a. Job strain: one job demand with no job resources, or two demands with only one job resource or none. High level of job demands: two job demands. High level of job resources: two job resources. [See Chapter 3 of the *OECD Employment Outlook*, 2014 (OECD, 2014).]

Source: Eurofound (2007), *Fourth European Working Conditions Survey*, Publications Office of the European Union, Luxembourg; and International Social Survey Programme Work Orientations Module (2005).

StatLink http://dx.doi.org/10.1787/888933287663

It makes obvious sense for employers to ensure good psychosocial working conditions and support workers with mental health problems. It is, of course, their duty to be attentive to workers' health, both mental and physical, but mental ill-health also has an economic impact in the form of reduced productivity. It has also been found to heighten the risk of work-related injuries for which employers are financially responsible (Butterworth et al., 2013). The overall cost of productivity loss (i.e. absenteeism, reduced work performance, increased turnover rates and compensation claims) due to poor psychological health is estimated at AUD 11-12 billion per year (Harvey et al., 2014).

This chapter addresses the policies and practices in Australian workplaces that seek to reduce psychosocial risks and so foster workers' mental health. It also assesses approaches to supporting workers with mental health problems in sickness management (often referred to as "return-to-work management").

Workplace policies to retain performance and productivity

Creating mentally healthy workplaces goes beyond reducing the costs associated with negative outcomes such as mental disorders, sickness absenteeism and psychological injury compensation claims. Organisational practices to improve employee psychological health and well-being for people with or without a mental health condition are also needed.

Addressing psychosocial risks at work

Australia has no explicit legislation in place specifically intended to address psychosocial risk factors at work. While Work Health and Safety (WHS) legislation is a state responsibility, harmonised model laws for WHS were adopted in the Commonwealth, territories and most Australian states in 2011 to provide all workers in Australia with the same standard of health and safety protection. However, these laws have kept the traditional focus on workplace physical hazards, injuries, and illnesses notwithstanding that this legislation defines "health" to include "psychological health" (Safe Work Australia, 2012a).

Employers' responsibility for detecting and tackling psychosocial risks at work is implied in the notion of the duty to ensure the health and safety of people in the work environment. No Codes of Practice to support the harmonised model laws have been developed specifically for the management of psychosocial risks in the workplace, such as high job demands and complexity, low job control, effort-reward imbalance, job insecurity, (lack of) colleague and supervisor social support, and workplace conflicts or bullying. Employers and labour inspectors thus have no clear regulatory framework to guide them in managing work-related psychosocial risk factors. Yet 44% of the working population feel that issues in the workplace are a source of stress (APS, 2014).

The lack of explicit psychosocial safety legislation may result in low employer investment in promoting good mental health. In 2010, PricewaterhouseCoopers adjudged that only 1 500 corporate and government employers offered, to their employees, health assessment and intervention programmes. To put that number in perspective, it accounted for only 3.6% of the more than 11 million Australian employees (PricewaterhouseCoopers, 2010).

The efficacy of WHS legislation is often evaluated by looking at trends in the number of work-related injury claims, even though it is a very narrow approach given that most workers do not file injury claims (Safe Work Australia, 2011).

When it comes to claims for work-related mental health problems, the numbers that are accepted have declined over the past decade after a sharp increase between 1997-98 and 2003-04. Whether the decline can be ascribed to better compliance with WHS regulations is hard to say, as other factors, too, come into play. One such factor is that claims for mental disorders are among the most expensive, prompting governments to introduce special legislative thresholds in order to reduce costs (Guthrie et al., 2010). Consequently, rejection rates have risen over the past decade. (There is further discussion of the workers' compensation system below).

Although WHS legislation does not specifically regulate for psychosocial risk prevention at work, information on psychosocial risks and tools for assessing and addressing them are readily available. For example, the Mentally Healthy Workplace Alliance – a joint nationwide move by business, community and government – commissioned a report in 2014 with the title, "Developing a mentally healthy workplace" (Harvey et al., 2014). It contained information on:

- workplace factors that affect mental health
- workplace intervention strategies that have proven effective in fostering a mentally healthy workplace.
- practical guidance for workplaces in implementing mental health interventions. It includes tools for situational analysis and a description of action that can be taken.

Other sources too, supply information and guidance. Comcare (the workers' compensation insurer covering, primarily, Commonwealth Government employees) adopts the UK Health and Safety Executive standards for psychological hazards and has a range of resources available as part of the "Creating mentally healthy workplaces" programme. The Australian Public Service Commission's guide "As One Working Together Promoting mental health and wellbeing at work" aims to empower managers and employees to work together to build inclusive workplace cultures and effective systems for promoting mental health in the Australian public service. Safe Work Australia (an independent statutory agency responsible for improving occupational health and safety and workers' compensation arrangements across Australia), in consultation with the Commonwealth Government, state and territory WHS regulators, has developed a number of publications including a "Guide for preventing and responding to workplace bullying" and a factsheet on "Preventing psychological injury under Work Health and Safety laws". The Black Dog Institute, a non-profit organisation that researches and combats mood disorders, runs education programmes to improve understanding of mental health in the workplace. The Australian

Psychological Society, for its part, has devised the Psychologically Healthy Workplace Program – a four-step assessment to evaluating an organisation's ability to meet six key indicators of mental health and well-being.[1] Furthermore, WHS regulators in the different states and territories provide information on supporting mental health in the workplace on their websites.[2]

The role of occupational health specialists in workplace health and safety

Realising the health benefits of work for all Australians requires co-operation between many stakeholders, including government, employers, unions, insurance companies, legal practitioners, advocacy groups, and the medical, nursing and allied health professions (AFOEM, 2010). Unlike several other OECD countries, Australia does not require employers to seek support from occupational health specialists as part of their WHS obligations. Private occupational health practices do exist, however, that offer employers support in, for example, health checks and workplace risk assessments. Nevertheless, occupational health remains a specialisation where there are very few practitioners. In 2008, there were only 270 specialists in occupational and environmental medicine (Donoghue, 2008).

All in all, if WHS legislation were to include specific, targeted requirements for the management of psychosocial risks in the workplace, employers would probably be more inclined to invest in this. Little information is available on how well the mental health of Australian employees is protected in the workplace. Data on the psychosocial safety climate in Australian industries suggest that, in most sectors, workers' mental health is at risk, albeit moderately (Dollard et al., 2012). Despite the widespread understanding of the need for mentally healthy workplaces, insufficient use is made of the many services that seek to translate it into action.

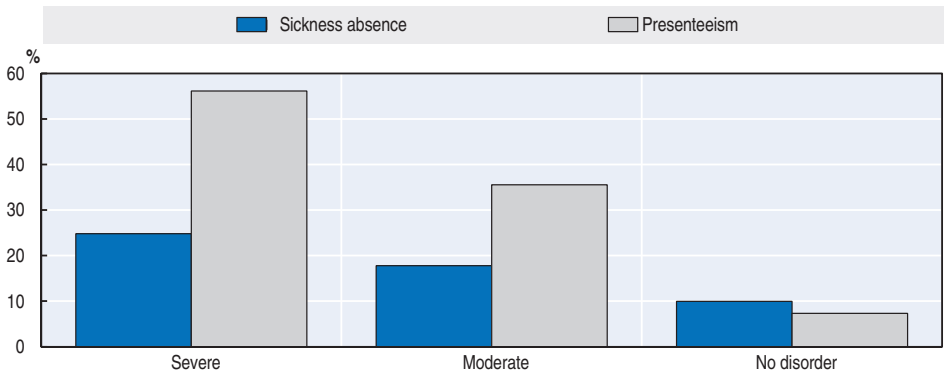
Support for those struggling at work

It is difficult to perform well at work while grappling with mental health problems (Figure 4.4). Thirty-six per cent of workers with mild-to-moderate mental health problems and 56% of those with severe problems report having trouble doing their job properly due to their health problems. Being present at work but unable to do the job is known as "presenteeism", and employees with mental health problems are five to eight times more likely to report presenteeism compared to employees without mental health problems. Presenteeism that stems from poor mental health has been found to be more costly than absenteeism for mental health reasons because it is so much more prevalent (Sanderson et al., 2006). Other studies also find that

presenteeism is common among people who suffer from mental ill-health, which points to the huge hidden costs for employers who fail to invest in supporting such workers (Esposito et al., 2007; Lerner and Henke, 2008).

Figure 4.4. **Poor mental health is a serious factor in absenteeism and presenteeism**

Sickness absence and presenteeism rates by mental health status, 2011-12



Note: Sickness absence is defined as being absent from work for at least one day in the previous two work weeks due to sickness. Presenteeism is defined as one or more days in the last four weeks when a worker has been totally unable to manage or has had to cut down on work, study, or day-to-day activities due to mental health problems.

Source: OECD calculations based on the ABS National Health Survey 2011-12.

StatLink http://dx.doi.org/10.1787/888933287672

Successful interventions that address presenteeism among workers with mental health problems are scarce in Australia. Employee Assistance Programmes (EAPs), however, which employers can offer their workers to help them with mental health or other psychosocial problems, could help fill the gap to some extent (Box 4.1). Although companies are thought to widely provide EAPs (Compton and McManus, 2015; Kirk and Brown, 2003 and 2005), there are no estimates of the percentage that do so, nor of whether there are wide differences between small-to-medium-sized enterprises (SMEs) and large. In a report published in 2014, market researchers suggested that, in certain industries, the usage rate of EAPs within companies was only 5% (Harkness, 2014), while other studies put the figure at between 4% and 8% (Compton and McManus, 2015).

Thorough evaluations of EAPs are largely lacking. They are often conducted as simple before-after studies with no control groups. That being said, they do point to positive effects on mental health and productivity

outcomes (Kirk and Brown, 2003). Moreover, employers report that they value EAPs and see them as an important part of their human resource management practices. Similarly, they score high levels of employee satisfaction (Compton and McManus, 2015; Kirk and Brown, 2003).

Box 4.1. **Employee assistance programmes in Australia**

Employee assistance programmes (EAPs) provide assessments, referrals, and short-term counselling as measures to help employees and their families address problems that could influence their performance in the workplace. Employers pay for such services, but do not know which workers use them.

Originally, EAPs were developed to counter substance abuse but, since the 1990s, other personal and social problems have become the prime factor. In Australia, workers can easily access EAPs through self-referral.

Counselling is the core activity and lasts, on average, three to four sessions. However, many EAP providers place their programme in a broader human resource context and offer a wider range of services – e.g. workplace and worker wellness programmes, such as general stress management programmes available to all employees.

EAPs are said to have become an established service in Australian industries and organisations, also among SMEs. They are frequently included as an employee benefit in bargaining agreements and seen as evidence of an employer's duty of care.

Another way in which work-related support may be provided is through the Disability Discrimination Act (DDA, 1992). It requires employers to make workplace adjustments for employees with disabilities where necessary and reasonable, which includes flexible working hours. However, what deters many employees with mental illnesses from seeking appropriate workplace assistance is having to disclose their illness to their employers (Department of Education, Employment and Workplace Relations, 2008; SANE, 2011). Such fears of stigma are founded. Research in 2012 among 254 employers from SMEs found that 70% were reluctant to hire workers with mental health problems, while 30% thought that they were not suited to the work in their company (WISE Employment, 2012).

To combat stigma, mental health awareness programmes and anti-stigma campaigns have been run throughout Australia over the past two decades. Some mental health literacy programmes specifically target the workplace. They include *beyondblue's* National Workplace Program, the Black Dog Institute's workplace mental health programmes, the Australian Human Rights Commission's practical guide for managers on workers with mental illness, and the Australian Public Service Commission's guide "As One Working Together Promoting mental health and wellbeing at work".

Such campaigns and programmes seem not to have got through to SMEs, however, a worrying finding as they employ 70% of the labour force. Indeed, 46% work for enterprises with less than 20 employees and 24% for companies that employ between 20 and 199 (Department of Industry, Innovation, Science, Research and Tertiary Education; 2012).

A more recent initiative, Heads Up, was jointly launched by the Mentally Healthy Workplace Alliance and *beyondblu*e in 2014. It is a website that offers free tools to organisations for fostering mentally healthy workplaces. There is, for example, an interactive tool for setting and prioritising goals, identifying areas of risk, and developing a stepwise approach to creating a mentally healthy workplace. Whether *Heads Up* will have greater success than existing programmes remains to be seen.

Nevertheless, the sheer range of workplace mental health literacy information websites and schemes around shows that the knowledge and know-how for supporting people with mental health problems at work is very much available. Still, firm evidence of their successful implementation and effectiveness is lacking.

Finally, the Department of Social Services funds a programme called Job in Jeopardy, which seeks to help workers with illness, injury, or disabilities to stay in work. The service is free and administered by the Disability Employment Services (DES). Either employees or their employer could turn to Job in Jeopardy and directly request assistance from a DES provider. If deemed eligible, the employee will be registered with the respective DES provider. The service includes:

- advice on redesigning jobs
- a workplace assessment to see what changes may facilitate work
- workplace changes that enable workers to keep their jobs
- specialised equipment that would help workers perform their task properly.

Eligibility criteria for Job in Jeopardy are not restricted to disability. They require only that employees should have worked at least eight hours per week on average for the previous 13 week. Furthermore, the DES provider should have assessed the employee as requiring assistance available through DES to maintain their employment and likely to require ongoing support (Disability Employment Services, 2014). Although that condition makes the programme much more accessible to people with mental health issues, very few of them have taken up the service. Employment service providers, employers and employees all seem unaware of the support that Job in Jeopardy can offer to workers with mental health problems (Department of Education, Employment and Workplace Relations, 2008a).

Managing sickness absence and return-to-work

For workers whose mental health problems keep them out of the workplace, timely sickness management is essential. Research has shown that the longer sick leave is the slimmer are the chances of resuming work (OECD, 2015a; Koopmans, 2008). In light of that finding and the acknowledged fact that work can contribute to recovery, early action through a return-to-work plan and workplace support is critical.

Given the relatively high proportion of workers with mental health problems who take sick leave (Figure 4.4) and do so for longer spells (OECD, 2012), tailored return-to-work strategies should be a priority. The following sections describe the roles of three main players in sickness management: the employer, the government, and general practitioners.

Employers have few return-to-work responsibilities

Employers have very few incentives to invest in return-to-work management. The Fair Work Act (2009) requires that all employees (with the exception of casual workers) receive 10 days paid personal or carer's leave per year, which includes absences related to personal sickness or injury. This is a relatively lax sick pay requirement compared to countries like the United Kingdom where employers have a half-year statutory sick pay obligation and the Netherlands, where the sick pay obligation for employers is up to two years (OECD, 2014b; OECD, 2014c).

Australian employers do not have to work with sick employees to help them return to work or supply any support measures. This is once more in sharp contrast to other OECD countries. The Netherlands again, Norway, and Sweden all require employers and employees to agree on return-to-work action plans within eight weeks of an employee going sick. Both sides have responsibilities (OECD, 2015a). In the Netherlands, for example, if employers fail to abide by the terms of the return-to-work agreement, the sick pay liability period can be lengthened. If employees do not comply, their disability benefit may be reduced (OECD, 2014c).

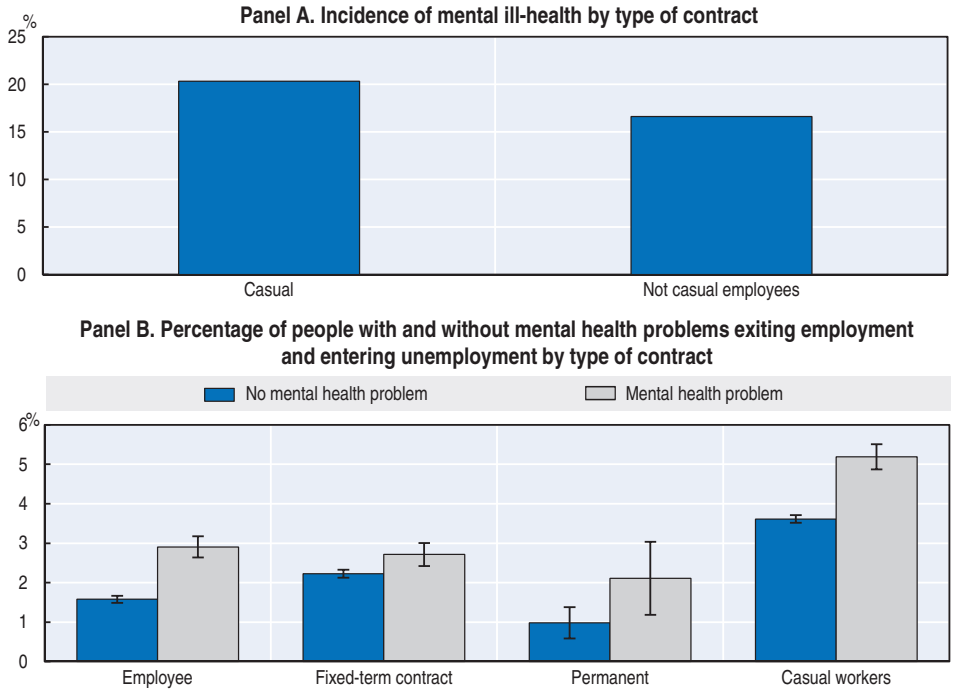
The limited nature of Australian employers' sick leave and return-to-work management obligations can have detrimental effects on the ability of workers with mental health problems to hold down jobs sustainably. Research has shown that workers on long-term sickness absence are at greater risk of sliding into disability and unemployment (Helgesson et al., 2015). In Austria, for example, longer sickness absences for reasons of poor mental health predict labour market exit on the grounds of disability seven years later (OECD, 2015b). In other words, leaving workers who are absent because of mental ill-health to fend for themselves increases the chances

that their sickness will become long-term and that they will eventually become estranged from the labour market.

Casual workers face the greatest barriers to staying in work

Casual workers are in an especially vulnerable position as they are not entitled to any sick pay and can be fired without notice. Data show that they have the hardest time staying in work. They are also more prone to mental health conditions, and those that actually experience them are more likely to lose their job than permanent or temporary workers (Figure 4.5). Furthermore, when casual workers (regardless of whether they have mental health issues or not) find another job, it is often casual again (Figure 4.1), making it difficult to break the vicious circle of poor mental health and short-term, insecure employment. And since approximately 25% of all employees in Australia are casual workers, a large proportion of society is affected.

Figure 4.5. **Casual workers, mental ill-health and unemployment**



Source: OECD calculations based on the Household, Income and Labour Dynamics in Australia survey.

StatLink http://dx.doi.org/10.1787/888933287687

The workers' compensation system

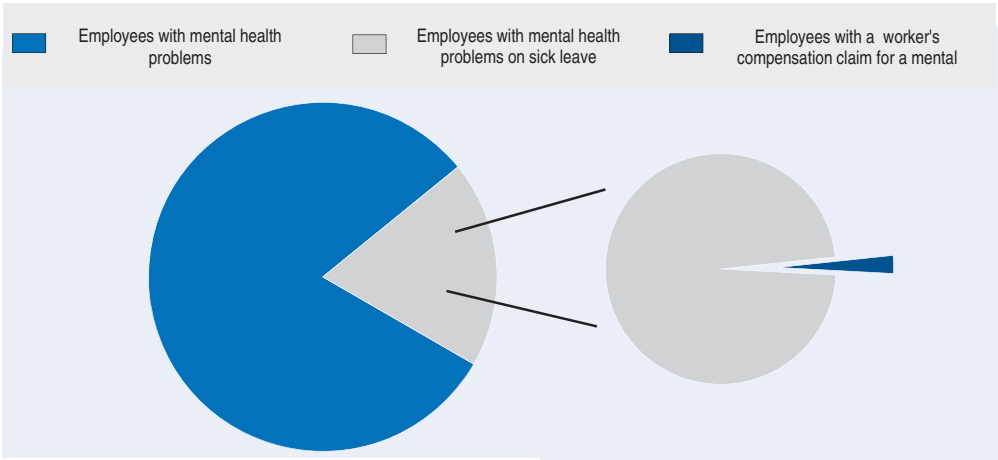
Employers are only responsible for sickness management in the event of work-related injuries or illness under the terms of Australia's workers' compensation legislation, which is statutory and run as no-fault insurance. Although state-run workers' compensation schemes differ according to the governments, they all require employers to take out insurance for compensating workers in the event of them sustaining any injury (mental or physical) in the course of their employment. If a worker is injured or falls ill as a direct result of their job, then associated work absences, medical treatment, and return-to-work programmes are all paid for and managed by the employer's workers' compensation insurance.

The system, however, applies only to a very restricted number of people with mental health problems – a mere fraction of them receive compensation for sick leave on the grounds of their condition (Figure 4.6). The share of workers' compensation claims for mental disorder is similarly small: only 5.9% of all workers' compensation claims in 2012-13 (Safe Work Australia, 2013).[3] If an employee experiences mental health problems as a result of factors in the workplace, the workers' compensation claim process can appear daunting and cause unnecessary distress. There are significant differences in the time taken for injured employees to lodge psychological injury claims compared to other disease claims; a median of 51 days compared to 29 days, respectively.

It is arguable whether return-to-work support for people with mental health problems under workers' compensation arrangements is effective. No data are available on the return-to-work rate of people with mental health claims compared to other claims. However, qualitative research suggests that mental health claims yield poorer work outcomes. Interviews with injured persons who have submitted a mental health claim, GPs, employers, and compensation agents show that mental health claims are complex to manage – partly because it is difficult to assess when a return to work is feasible. As a result, many people with mental health claims receive compensation for long periods and do not return to work (Brijnath et al., 2014). The finding is backed up by data showing that mental health claims have the longest median duration – 14.2 weeks compared to 5.4 for all claims (Safe Work Australia, 2013). It is also more difficult to propose alternative tasks to employees who suffer from mental health complaints than to their peers with physical injuries (Brijnath et al., 2014).[4]

To summarise, Australia clearly lacks policy for workplace sickness and return-to-work management for employees with mental health problems. Although employer support for them is mandatory, it seems inadequate and reaches only a very small group. In essence, anybody struggling with a mental health condition that is not related to work is left to fend for themselves when it comes to managing their health and return-to-work.

Figure 4.6. **Only a fraction of all people with mental-health-related sickness absence submit compensation claims**



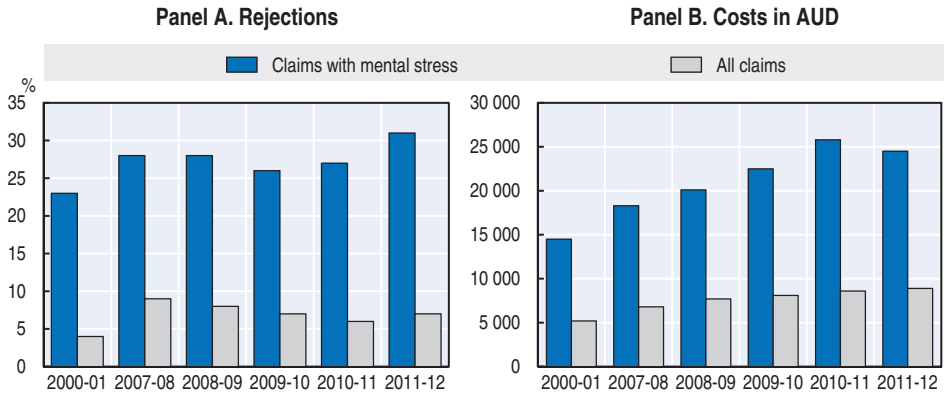
Note: Data on the number of workers' compensation claims come from Safe Work Australia and are based on diagnosed mental illness. All other data come from the National Health Survey and are based on self-assessed mental health status.

Source: OECD calculations based on data from the National Health Survey 2011-12 and Safe Work Australia (2012), *Australian Workers' Compensation Statistics 2011-12*, Safe Work Australia, Canberra.

StatLink http://dx.doi.org/10.1787/888933287690

Figure 4.7. **Mental disorder claims are increasingly denied as costs rise**

Rejection rates and median costs per workers' compensation claim, 2000-12



Source: Australian workers compensation statistics 2012-13.

StatLink http://dx.doi.org/10.1787/888933287700

Limited government support in sickness management

The governments provide no sickness management services for people on sick leave. When employees use up the employer's 10-day sick pay obligation, any further leave is unpaid and they generally become reliant on personal or family financial support. Only for those in "financial hardship" may the Commonwealth Government make sickness allowance available. To be eligible for sickness allowance (which is purely financial assistance), employees must have a job when they go on sick leave and have one to return to when it is over. Furthermore, eligibility is subject to asset and income tests, which rules out most workers. In 2011, for example, there were only 6 705 recipients of full or partial sickness allowance (Department of Families, Housing, Community Services and Indigenous Affairs, 2012). Eligibility throughout sick leave is dependent on recipients seeking medical assistance and regularly supplying proof that their condition prevents them returning to work.

Sickness allowance is usually well below the income of average earners, which prompts some to take out personal income protection insurance (IPI) against any incapacity to work caused by accident or illness. IPI is available to all employees and the self-employed. It is a particularly important safeguard for the latter as they are seldom eligible for workers' compensation. IPI policies do not generally apply to the unemployed, particularly those with mental health problems, as benefits are paid only if unemployment is the result of incapacity to work. Moreover, IPI is expensive and unaffordable for most employees on minimum or even average wages.

In the absence of a general sickness management system at the workplace level, only greater government involvement can prevent long sickness absences from eventually ending up in the benefit system. Confronted with a similar problem, some countries have faced up to their duties in sickness absence management. The United Kingdom, for example, has rolled out a national Health and Work Service (HWS) to plug the gap in occupational health support for individuals struggling to get back to work. HWS conducts in-depth assessments of how a worker's health affects their ability to work and supplies advice on how people on sick leave can be supported in their return to work. Assessments are conducted early, after around four weeks of sickness absence. GPs and even employers can refer workers to the HWS. Occupational health advisors case-manage sick employees and collaborate on a return-to-work plan with the employees, the employer, and treating GP (OECD, 2014b). Austria has a similar system, called *fit2work*, co-funded by the government but administered by health insurance bodies. The health insurers contact employees within 40 days of their taking sick leave, supply general information and, where necessary, provide counselling and return-to-work support through professional consultancies (OECD, 2015b).

Mental health problems and disability need to be disconnected

Although government funding to help employers recruit and retain employees with mental health problems is available, it is restricted to people with a diagnosed disability. However, as most mental disorders are not related to disability (Table 4.1), making eligibility for government support dependent on disability means it does not reach people with mental health problems.

Table 4.1. **Most mental disorders do not lead to mental disability**

Proportion of people with a mental disorder, by severity and co-morbidity, who also report a disability

		Disability status		
		No disability	Disability	*Total*
Mental health status	Severe disorder	65.1	34.9	*100.0*
	Moderate disorder	82.3	17.7	*100.0*
	Comorbid disorder	73.6	26.4	*100.0*
	Mental disorder only	96.0	4.0	*100.0*
	No disorder	94.3	5.7	*100.0*
	Total	90.9	9.1	*100.0*

Source: OECD calculations based on the Survey of Health and Retirement (SHARE) covering the population aged 50-64.

StatLink http://dx.doi.org/10.1787/888933287847

There are three financial incentives for employers to help people with mental disorders enter or remain in work: the Wage Subsidy Scheme[5], the Employment Assistance Fund, and the Supported Wage System (Box 4.2). They are designed to encourage only employers who take on and retain staff who meet disability criteria, such as suffering from a disability that has lasted or is likely to last two years.

The strong but misguided focus on disability is reflected in employers' lack of awareness of government support for recruiting and retaining people with mental health problems. Research conducted in 2008 on the attitudes of employers to hiring people with mental illness found that they were unlikely to consider government resources – such as *JobAccess* – as a source of information or advice on work-related mental health issues. The main reason was that resources were very disability-oriented, and employers reported that they did not necessarily understand or associate mental illness with disability. Indeed employers considered that *JobAccess* was so closely associated with disability that it failed to draw their attention or spark their interest (Department of Education, Employment and Workplace Relations, 2008b).

Low employer awareness of mental health government services is unfortunate, as several public bodies provide low-threshold information on dealing with mental ill-health at work. The websites of the Department of Social Services (specifically, the JobAccess website), Safe Work Australia (SWA), and the Australian Human Rights Commission (AHRC), for example, all offer practical information and best practice guidelines and policies on:

- Combatting workplace discrimination and harassment;
- Understanding mental illness in order to reduce stigma;
- Preventing and managing mental illness in the workplace;
- Examples of "reasonable adjustments" in the workplace for employees with mental health problems;
- Where to find assistance and other resources.

Also interesting is the freely accessible online workplace adjustment tool. It is intended primarily for SMEs that have limited resources and cannot afford workplace adjustment services. The tool provides practical information on adjustments relevant to specific disability types that include a number of mental health conditions. There has, however, been no assessment of how widely employers use the tool.

Box 4.2. **Government incentives for workplace support for people with disabilities**

Wage Subsidy Scheme

It provides funding of up to AUD 1 500 per employee to employers who hire workers with a disability. The terms of employment should be standard and last at least 8 hours a week for 13 weeks, with the reasonable expectation that the employee will be kept on after the13 weeks.

Supported Wage System

The Supported Wage System (SWS) allows companies to pay productivity-based, or pro-rata wages, which are lower than normal wages). A reliable process of productivity-based wage assessment determines what a fair wage is for the employees who qualify for SWS.

Employment Assistance Fund

The Employment Assistance Fund (EAF) financially assists i) employees with a disability and ii) employers who make workplace modifications or provide the equipment and services that employees require to perform their duties properly. To qualify, employees must have suffered from their disability for at least two years. However, specialised support for mental disorders (including mental health awareness training) is capped at AUD 1 500 per employee per 12 months.

General practitioners play an important part in return-to-work

GPs play an important role in employees' return-to-work process because they decide whether an employee's state of health warrants leave from work and for how long, and because they draw up medical certificates to that end (AMA, 2011). Employers may ask for a medical certificate as proof that a worker is sick and therefore entitled to sick pay, while acceptance of a compensation claim is also dependent on GP certification.

Although they are called upon to assess how illness or injury might affect the ability to work, GPs are not trained to that effect. For example, the mental health training programmes available to GPs (Chapter 3) do not include information on sickness absence related to mental health. Compared to physical injuries or diseases, medical certificates for people with mental health problems more often declare patients unfit for work instead of suggesting alternative duties.

However, there is some debate as to whether a GP's involvement in return-to-work should go further than merely writing out medical certificates. In its position statement on helping people return to work, the Royal Australasian College of Physicians and the Australasian Faculty of Occupational and Environmental Medicine argue that treating doctors should play a more active role in return-to-work by educating patients and employers in best practices and getting across to them that activity, which includes work, is integral to recovery. The College and the Faculty recommend that treating doctors should be encouraged to play an active role in shaping patient and employer attitudes to disability, recovery, and rehabilitation. The inference is, of course, that doctors themselves should be well educated on the matter, and both College and Faculty acknowledge that doctors should be routinely trained in return-to-work management (Royal Australasian College of Physicians, 2010).

Round-up and recommendations

In policy to support people with mental health problems in the workplace Australia boasts a particular strength – the wide availability of mental health and work knowledge. Numerous government and non-government bodies offer information on interactions between mental health and work and the support that needs to be provided in the workplace, be it in the form of risk prevention, mental health promotion, or specific interventions. There are also some good practices in supporting people with mental health problems, such as the employee assistance programmes.

However, workplace policy to foster employees' mental health and support those who suffer from poor mental health is a significant weakness

in the Australian system. Work Health and Safety legislation requires employers to protect their employees' health. Other than making clear that "health" in these laws means physical as well as psychological health, they contain no discrete regulation aimed at protecting employees' mental health. This could have the effect that employers disregard the promotion of mental health in the workplace. It also makes it more difficult for labour inspectors to address psychosocial risks or take suitable action. While there are ample services seeking to raise awareness of workplace mental health and advocating action to prevent or reduce work-related stress, few employers take advantage of them.

Suitable sickness absence and return-to-work management for workers with mental health problems is also sorely lacking. While the workers' compensation system may function well when it comes to physical injuries and illnesses, the same cannot be said of work-related mental illness. Furthermore, the system diverts attention and responsibility away from the much larger group of people who suffer from mental disorders that are not directly caused by work. And with employers enjoying such lax sick-pay obligations and the dearth of other incentives to support return-to-work management, employees with poor mental health who struggle to resume work are left to fend for themselves.

Finally, there are few government measures that address the shortage of workplace psychosocial risk prevention, mental health promotion, and sickness management. The government services that are available fail to meet the needs of people with mental health problems, because they often make disability an eligibility criterion. As a result, employers do not even think of the government as a possible source of support for employees with mental health problems.

Address psychosocial risks at work more effectively

- *Improve regulations on psychosocial risk prevention at work.* Work Health and Safety (WHS) legislation should put greater emphasis on psychosocial risks at work in the light of the close relationship between poor psychosocial conditions in the workplace and mental ill-health.
- *Support employers and labour inspectors*. Guidelines on psychosocial risk assessment and prevention plans are needed to support employers and labour inspectors. Codes of practice and guidelines could be developed on, for example, job strain, support from co-workers and supervisors, and job insecurity, as all have been found to be significant predictors of mental ill-health.
- *Monitor compliance with labour law.* Rather than monitoring work-related mental illness claims as an indicator of effective psychosocial risk policy in

companies, WHS authorities should consider the psychosocial risk assessments that are conducted and the availability of prevention plans. Furthermore, indicators such as staff turnover and sickness absence rates could provide additional information.

Improve mental health support in the workplace

- *Make better use of workplace mental health programmes.* A number of institutional bodies in Australia have developed a range of tools for employers and employees designed to improve psychosocial work environments and foster good mental health. They include programmes from *beyondblue*, the Black Dog Institute, the Mentally Healthy Workplace Alliance, and the Australian Psychological Society. Uptake of these tools by employers needs to be stimulated. Labour inspectors could monitor the use of those services, especially in SMEs where the stigma that attaches to mental ill-health remains pervasive. Publicising or benchmarking employers who use the programmes could also improve uptake.

- *Strengthen the use of occupational mental health services.* Work-related mental health support is available in the form of employee assistance programmes, but uptake is low. Ways to stimulate it should be sought. Another possibility could be to expand the role of the occupational health services, still traditionally focused on physical health, to include occupational psychologists who could assist employers in addressing mental health at work.

- *Make government services more accessible to people with mental health problems.* Workers with mental health problems cannot currently access government occupational health services, because eligibility is predicated on the disability criterion. Yet the recurrent nature of mental health problems and the strong stigma attaching to them make people with mental health problems more prone to losing their job and not finding another one. In that regard, government services like the Employee Assistance Fund or the Supported Wage System can be useful.

- *Improve employer awareness of governmental services.* Not only should government occupational health services be opened up to people with mental health problems, employer awareness of the services also needs to be improved. Employers make little use of the one programme currently available for helping them to keep employees with mental health problems in work, Job in Jeopardy, simply because they are unaware of it. Such government schemes clearly need to be more widely publicised. Another way to boost take-up could be to disconnect Job in Jeopardy from the Disability Employment Services and transfer it to a government service that is unrelated to disability.

Ensure that sickness management is available to all employees

- *Make the return to work a shared responsibility for employers and employees.* Because of the stigma that attaches to their condition, employees who suffer from mental ill-health find it particularly hard to return to work without workplace support. Procedures should be introduced that require employer and employee to work together to that end – through mandatory return-to-work action plans, for example. The preparation and implementation of such plans would need to be monitored, however. Non-compliance could be sanctioned by extending the employer's sick-pay obligation, for example, or reducing the employee's sick pay entitlement.
- *The governments need to assume a role in sickness management.* To fill the gap in workplace sickness management services, governments should play a more active role. They should try providing occupational health support to employed people struggling to get back into work due to sickness. The Health and Work Service in the United Kingdom and Austria's *fit2work* programme are good examples to emulate. A low-threshold health and work service along those lines could also house the Job in Jeopardy programme.

Notes

1. The six key indicators of mental health and well-being are: supportive leadership; employee engagement; role clarity; learning, development and growth opportunities; appraisal and recognition; and work-life balance. The four-step assessment consists of: i) an online survey among employees to measure the six indicators; ii) collection of human resource data; iii) comparison of survey data against national benchmark data; and iv) provision of a report with the results.
2. See for example www.worksafe.vic.gov.au/safety-andprevention/health-and-safety-topics/stress (accessed 2 September 2015); www.worksafe.qld.gov.au/news/2013/psychosocial-safety-at-work (accessed 2 September 2015).
3. Workers' compensation claims are also classified by injury mechanism, which includes the mechanism of mental stress as a cause of either a physical or mental work injury. The vast majority (95%) of mental work injury claims in the past 10 years have been due to mental stress (Safe Work Australia, 2013).
4. Currently, Safe Work Australia is undertaking a project aimed at improving return to work of people with a compensated mental health

claim. Part of this project includes evaluating and comparing return to work rates of people with mental health claims and other types of claims.

5. The effectiveness of wage subsidies has been widely questioned (Australian Human Rights Commission, 2005), and seem to have been particular unsuccessfully when it comes to mental disorders. In the 2012 evaluation of Job Services Australia, employers claimed a wage subsidy would have little or no effect on their decision to hire a jobseeker with a mental health condition (Department of Education, Employment and Workplace Relations, 2012).

References

AFOEM – Australasian Faculty of Occupational and Environmental Medicine (2010), "Australian and New Zealand Consensus Statement on the Health Benefits of Work – Position Statement: Realising the Health Benefits of Work", The Royal Australasian College of Physicians, Sydney.

AMA – Australian Medical Association (2011), *Guidelines for Medical Practitioners on Certificates Certifying Illness 2011*, Australian Medical Association, Kingston.

APS – Australian Psychological Society (2014), *Stress and Wellbeing in Australia Survey 2014*, Australian Psychological Society, Melbourne.

Australian Human Rights Commission (2005), *People with Disability in the Open Workplace*, Interim report of the national inquiry into employment and disability, www.humanrights.gov.au/publications/national-inquiry-employment-and-disability-interim-report-index (accessed 28 May 2015).

Brijnath, B. et al. (2014), "Mental Health Claims Management and Return to Work: Qualitative Insights from Melbourne, Australia", *Journal of Occupational Rehabilitation*, Vol. 24, No. 4, pp. 766-776.

Butterworth, P., L. Leach and K. Kiely (2013), *The Relationship Between Work Characteristics, Wellbeing, Depression and Workplace Bullying: Summary Report*, Safe Work Australia, Canberra.

Butterworth, P. et al. (2011), "The Psychosocial Quality of Work Determines Whether Employment Has Benefits for Mental Health: Results from a Longitudinal National Household Panel Survey", *Occupational and Environmental Medicine*, Vol. 68, pp. 806-812.

Compton, R. and J. McManus (2015), "Employee Assistance Programs in Australia: Evaluating success", *Journal of Workplace Behavioral Health*, Vol. 30, No 1-2, pp. 32-45.

Department of Education, Employment and Workplace Relations (2012), *Evaluation of Job Services Australia 2009-201*2, Commonwealth of Australia, Canberra.

Department of Education, Employment and Workplace Relations (2008a), *Promoting Best Practice Use of Job in Jeopardy Assistance and Intermittent Support*, Commonwealth of Australia, Canberra.

Department of Education, Employment and Workplace Relations (2008b), "Employer Attitudes to Employing People with Mental Illness", Commonwealth of Australia, Canberra.

Department of Families, Housing, Community Services and Indigenous Affairs (2012), "Income Support Customers: A Statistical Overview 2011", *Statistical Paper No.10*, Commonwealth of Australia, Canberra.

Department of Industry, Innovation, Science, Research and Tertiary Education (2012), *Australian Small Business: Key Statistics and Analysis*, Commonwealth of Australia, Canberra.

Disability Employment Services (2014), "Job in Jeopardy Assistance Guidelines V2.7", Commonwealth of Australia, Canberra.

Dollard, M. et al. (2012), *The Australian Workplace Barometer: Report in Psychosocial Safety Climate and Worker Health in Australia*, University of South Australia, Magill.

Donoghue, A. (2008), "Occupational Medicine in Australia", *Occupational Medicine*, Vol. 58, p. 591.

Esposito, E. et al. (2007), "Mood and Anxiety Disorders, the Association with Presenteeism in Employed Members of a General Population Sample", *Epidemiologia e Psichiatria Sociale*, Vol. 16, No. 3, pp. 231-37.

Eurofound (2007), *Fourth European Working Conditions Survey*, Publications Office of the European Union, Luxembourg.

Guthrie, R., M. Ciccarelli and A. Babic (2010), "Work-related stress in Australia: The effects of legislative interventions and the cost of treatment", *International Journal of Law and Psychiatry*, Vol. 33, pp. 101-115.

Harkness, J. (2014), "Call for Employers to Tackle Barriers to EAP Use", AccessEAP, Workplace OHS, 25 September 2014, http://workplaceohs.com.au/workplace-culture/corporate-wellness-programs/analysis/employers-urged-to-better-promote-mental-health-service#.VEXgJ_mUccA (accessed 2 September 2015).

Harvey, S. et al. (2014), *Developing a Mentally Healthy Workplace: A Review of the Literature*, University of New South Wales, Sydney.

Helgesson, M. et al. (2015), "Sickness Absence at a Young Age and Later Sickness Absence, Disability Pension, Death, Unemployment and Income in Native Swedes and Immigrants", *European Journal of Public Health*, Advance Access published 28 January.

Kirk, A. and D. Brown (2005), "Chapter 18: Australian perspectives on the organizational integration of employee assistance services", *Journal of Workplace Behavioral Health*, Vol. 20, No. 3-4, pp. 351-66.

Kirk, A. and D. Brown (2003), "Employee Assistance Programs: A Review of the Management of Stress and Wellbeing through Workplace Counselling and Consulting", *Australian Psychologist*, Vol. 38, No. 2, pp. 138-143.

Koopmans, P., C. Roelen and J. Groothoff (2008), "Frequent and Long-term Absence as a Risk Factor for Work Disability and Job Termination Among Employees in the Private Sector", *Occupational and Environmental Medicine*, Vol. 65, pp. 494-499.

Lerner, D. and R. Henke (2008), "What Does Research Tell Us About Depression, Job Performance and Work Productivity?" *Journal of Occupational and Environmental Medicine*, Vol. 50, pp. 401-410.

OECD (2015a), *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264228283-en.

OECD (2015b), *Mental Health and Work: Austria*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264228047-en.

OECD (2014a), *OECD Employment Outlook 2014*, OECD Publishing, Paris, http://dx/doi.org/10.1787/empl_outlook-2014-en.

OECD (2014b), *Mental Health and Work: United Kingdom*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264204997-en.

OECD (2014c), *Mental Health and Work: Netherlands,* OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264223301-en.

OECD (2012), *Sick on the Job. Myths and Realities about Mental Health and Work*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264124523-en.

PricewaterhouseCoopers (2010), *Workplace Wellness in Australia. Aligning Action with Aims: Optimising the Benefits of Workplace Wellness*, PricewaterhouseCoopers, Sydney.

The Royal Australasian College of Physicians (2010), "Helping People to Return to Work: Using Evidence for Better Outcomes, a Position Statement", The Royal Australasian College of Physicians and the Australasian Faculty of Occupational & Environmental Medicine.

Safe Work Australia (2013), *Incidence of Accepted Workers' Compensation Claims for Mental Stress in Australia*, Safe Work Australia, 2013.

Safe Work Australia (2012a), *Guide to the Model Work Health and Safety Act*, Safe Work Australia, Canberra.

Safe Work Australia (2012b), *Australian Workers' Compensation Statistics 2011-12*, Safe Work Australia, Canberra.

Safe Work Australia (2011), *Work-related Injuries in Australia: Who Did and Didn't Receive Workers' Compensation in 2009-10*, Safe Work Australia, Canberra.

Sanderson, K. and G. Andrews (2006), "Common Mental Disorders in the Workforce: Recent Findings from Descriptive and Social Epidemiology", *Canadian Journal of Psychiatry*, Vol. 51, No. 2, pp. 63-75.

SANE (2011), "Working Life and Mental Illness", *SANE Research Bulletin 14*, Melbourne.

Saunders, S. and B. Nedelec (2014), "What Work Means to People with work Disability: A Scoping Review", *Journal of Occupational Rehabilitation*, Vol. 24, No. 1, pp. 100-110.

Stansfeld, S. and B. Candy (2006), "Psychosocial Work Environment and Mental Health – A Meta-analytic Review", *Scandinavian Journal of Work, Environment and Health*, Vol. 32, No. 6, pp. 443-462.

Thomas, C., M. Benzeval and S. Stansfeld (2007), "Psychological Distress After Employment Transitions: The Role of Subjective Financial Position as a Mediator", *Journal of Epidemiology and Community Health*, Vol. 61, No. 1, pp. 48-52.

WISE Employment (2012), *SMEs Attitudes to Employing People Who Have a Mental Illness*, WISE Employment, Melbourne.

Chapter 5

Improving the labour market participation of people with mental health problems in Australia

This chapter looks at the role Australia's benefit system plays in ensuring a secure income in periods of inactivity for people with mental ill-health and helping them return to the labour market. The chapter devotes particular attention to identifying mental health problems among jobseekers and the employment support provisions that are available. The chapter ends with a discussion of the recent reforms in the disability benefit system designed to halt the rise in numbers of claimants, and the impact they have on those with a mental disorder in particular.

People with mental health problems are more likely to lose and less likely to find jobs. Following this, the prevalence of mental ill-health is proportionally higher among the recipients of unemployment and other benefits than among people in work. Indeed, benefits and employment services play a critical role in protecting people with poor mental health when they are out of work and in helping them back into the labour market quickly and effectively.

Australia has a unique, means-tested benefit system for the most disadvantaged and equally unique employment services which focus heavily on service quality and rely entirely on private service providers to achieve employment outcomes. They use a range of instruments to assess jobseekers' mental health problems, identify the labour market barriers they cause, then help them into work.

However, there are a number of challenges in the system implying that many jobseekers with mental health problems do not receive appropriate services. This chapter discusses those issues, focusing particularly on ways to offer a better integrated health and employment service provision.

Australia has a uniquely privatised employment service system

The initial point of contact for anyone seeking the support of publicly financed social services is Centrelink, a public one-stop-shop managed by the Department of Human Services. With over 400 local offices, Centrelink is responsible for delivering benefit payments and a range of Commonwealth services. As part of its employment provision, Centrelink:

- registers unemployed people;
- determines their eligibility for benefit payment;
- assesses the "barriers" to the workplace that they face and how far removed they are from the labour market;
- directs jobseekers to an employment service provider.

As for the development of labour market policies and the administration of private employment services, they come under the aegis of the Department of Employment. Responsibility of private employment services for disabled people resides with the Department of Social Services and employment services in remote areas with the Department of the Prime Minister and Cabinet.

Alone in the OECD, Australia's employment services are fully privatised (Box 5.1), with a number of providers offering jobseekers support that varies in kind, intensity, and quality.

Box 5.1. **Privatisation of employment services in Australia over time**

The privatisation of Australian employment services goes back to 1994, when it started with the privatisation of employment counselling for long-term unemployed people. In 1998, Australia fully privatised its mainstream employment services leading to substantial reduction in the cost of achieving employment outcomes. Since then, the sole providers have been businesses and not-for-profit groups contracted by the Commonwealth Government's employment department. They are chosen through a competitive tendering process and evaluated according to a star rating system, which ranks providers according to their service quality and jobseekers' employment and educational outcomes.

The system has changed names several times in the course of renewed tendering – Job Network until 2009, then replaced by Jobs Service Australia (JSA), and now *jobactive* since July 2015 – and has evolved continuously in two main directions:

1. Increased activation – i.e. exerting pressure on jobseekers to find employment and leave the income support rolls;
2. The reduction of deadweight losses associated with paying fees to employment service providers for workers who can find employment without their help.

Source: This box draws heavily on the OECD reviews *Activating Jobseekers: How Australia Does It* (OECD, 2012) and *Back to Work: Australia. Improving the Re-employment Prospects of Displaced Workers* (OECD, forthcoming).

Services for jobseekers comprise a mainstream and special-needs provision operating in parallel to each other:

1. *Jobactive* is the new Australian Government's mainstream employment service under the aegis of the Department of Employment. It replaced Job Service Australia (JSA) in July 2015. Because much of this chapter covers policy prior to that date, it frequently refers to JSA.

   Jobactive's service provision is divided into three service streams. Each stream is designed to meet a certain level of jobseeker needs and barriers to employment, ranging from Stream A, for work-ready jobseekers, to Stream C, for those with the most complex, multiple barriers to employment. Funding levels vary accordingly – with providers' fees much lower for Stream A services and at their highest for Stream C.

   JSA used four service streams – from 1 to 4 – with Stream 4 catering to those with the severest barriers to employment and receiving the highest level of public funding.

2. The special Disability Employment Services (DES) under the responsibility of Department of Social Services: DES differentiates between disability management services (DMS) and disability employment support (DES-ESS).

There is also a specific programme for Remote Jobs and Communities under the responsibility of the Department of the Prime Minister and Cabinet, which will not be discussed further in this report.

When it comes to labour market programme (LMP) expenditure, Australia ranks in the bottom third of OECD countries. At about 0.3% of GDP in 2011, spending is very low – even lower than in other countries with little unemployment (OECD, forthcoming). Moreover, a relatively high share of total LMP expenditure goes into public employment services overhead costs and administration – in other words, monitoring unemployed people – which makes expenditure on actual labour market programmes even lower.

Different types of income support are available for the jobless

The four main income support schemes in Australia for the jobless are:

- Newstart Allowance (NSA) for unemployed people aged 22 and over;
- Youth Allowance (YA) (other) for 16-to-22 year-olds;
- Parenting Payment (PP) for parents with children under 6 (Partnered) or for lone parents with children under 8 (Single);
- Disability Support Pension (DSP) for people with a disability who are deemed unable to work for more than 15 hours per week and will be unable to do so over the following two years – later in this chapter referred to as the "two-year rule".

All four are social assistance, not social security, schemes. In other words, because there is no contribution requirement, claimants receive income support regardless of whether they have worked or not. However, income support payments are means-tested, i.e. subject to such strict caps on the income and assets of claimants and their partners that only those in direst need receive government financial assistance.

The stringent nature of eligibility criteria means that many unemployed people do not qualify for income support (see OECD, forthcoming, for a more detailed discussion). Evidence from the National Health Survey suggests that 56% of all unemployed people (as defined by the International Labour Organisation) were receiving NSA, YA, PP or DSP in 2011-12. Among people with a mental disorder, coverage was 64% (Table 5.1). The rates are slightly higher than those drawn from the longitudinal Household, Income and Labour Dynamics in Australia (HILDA) Survey. HILDA found that 47% of all unemployed people and 51% of those with mental health problems were covered by the four income support schemes. Among those who had recently lost their jobs, however, the share was only around 39% for both groups.

Table 5.1. **Many unemployed people do not qualify for income support**

Share of unemployed people receiving income support[a]

	All	Mental ill-health
NHS (2011-12)		
All unemployed	55.7	63.9
HILDA (2001-13)		
All unemployed	46.7	51.0
Recent unemployed[b]	38.9	37.8

a. Income support includes Newstart Allowance, Youth Allowance, Parenting Payments (Partnered and Single) and Disability Support Pension.

b. Recently unemployed people are those who were still employed in the previous year.

Source: OECD calculations based on the National Health Survey (NHS) and Household, Income and Labour Dynamics in Australia Survey (HILDA).

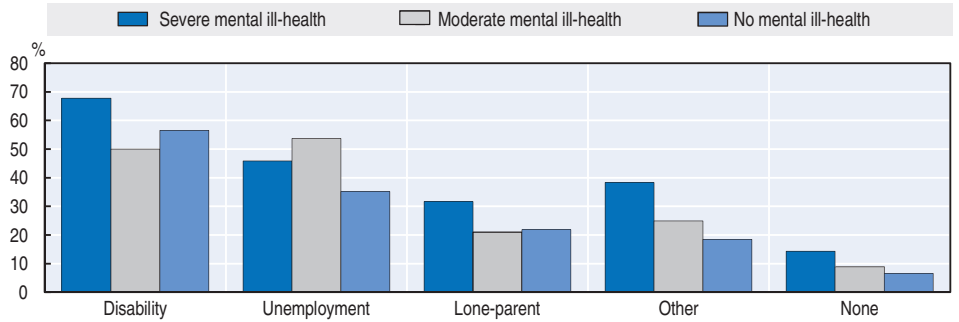
StatLink http://dx.doi.org/10.1787/888933287851

Not only is benefit coverage low in Australia, so are benefit payments (OECD, 2010). The base rate of NSA entitlement for a single person is around 17% of the average wage, while for DSP it is around 28% (Australian Government, 2015a). There is thus every chance that the jobless live in a low-income household, and possibly in poverty.

As Chapter 1 stresses, overall poverty levels are much higher among people with severe mental disorders than among those without such a disorder, and lie somewhere in-between when it comes to those with mild-to-moderate disorders. Those differences are, in great part, attributable to the fact that the risk of poverty is particularly high among people who are dependent on disability and unemployment benefits (OECD, 2012) (Figure 5.1). Being in work and not having to rely on benefits is the best way to stay out of poverty.

Figure 5.1. **The higher poverty risks among people with a mental health problem result from their greater benefit dependency**

Risk of poverty among people with severe, moderate or no mental ill-health, by type of benefit received, 2011-12



Note: Poverty risk is defined as the proportion of people with equivalised income below 60% of the median income. Other income support benefits include Carer Payment, Partner Allowance, Widow Allowance, Sickness Allowance, Austudy, ABSTUDY and Special Benefit, noting not all of these are job seeking payments.

Source: OECD calculations based on the ABS National Health Survey 2011-12.

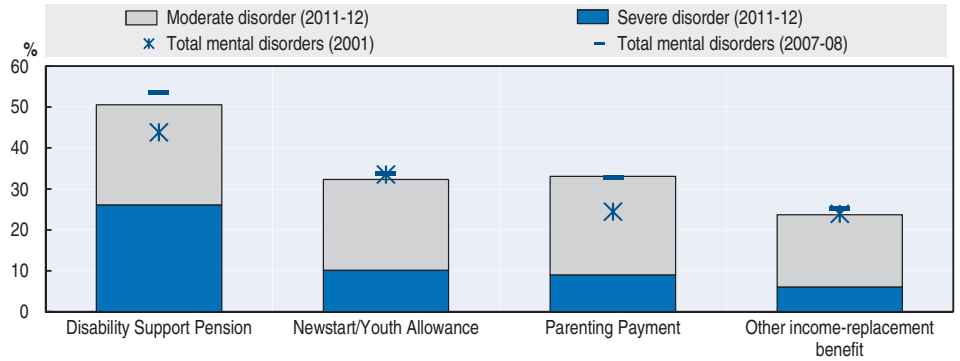
StatLink http://dx.doi.org/10.1787/888933287718

The prevalence of mental health problems among benefit recipients is high

The over-representation in Australia of mild-to-moderate mental disorders among welfare recipients compared to the population at large has already been well documented (Kiely and Butterworth, 2013; Butterworth, 2003). Estimates based on the National Health Survey of 2011-12 (using the Kessler Psychological Distress Scale [K10]) suggest that 32% of NSA and YA claimants and 33% of PP beneficiaries suffered from mental disorders, of which some one-third were severe (Figure 5.2). Among long-term unemployed people – i.e. jobless for more than a year – about 47% struggled with severe or mild-to-moderate conditions (not shown in Figure 5.2, but estimated based on the same data source). That share was nearly as high as among beneficiaries of the DSP disability scheme, where 51% were affected by mental ill-health in 2011-12. In the decade to 2011, the prevalence of mental disorders rose among DSP and PP recipients, but remained stable among those who were on NSA, YA, and other income-replacement benefits.

Figure 5.2. **Between one-quarter and one-half of all income support beneficiaries have a mental health problem**

Share of beneficiaries with a severe or moderate mental disorder as a total of each benefit scheme



Note: Other income support payments include Carer Payment, Partner Allowance, Widow Allowance, Sickness Allowance, Austudy, ABSTUDY and Special Benefit.

Source: ABS National Health Surveys 2001, 2007-08 and 2011-12.

StatLink http://dx.doi.org/10.1787/888933287723

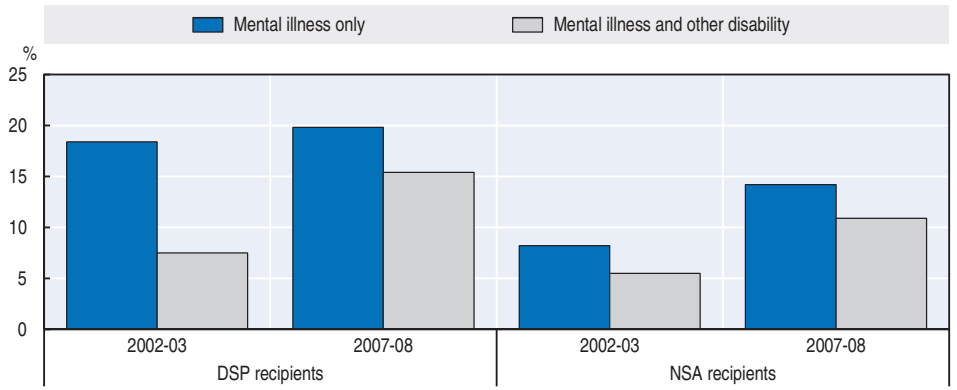
The estimates in Figure 5.2 are only slightly higher than the prevalence rates based on administrative data from the Research and Evaluation Database (RED) of the Department of Employment reported by Black and Lee (2009). Their study found that 25% and 33% of NSA and DSP recipients, respectively, suffered from mental illness in 2007-8 as a primary or secondary condition. However, their data were the records of all income support beneficiaries in Australia and relied on medical certificates to classify mental disorders.[1] As a result, they underestimated the real prevalence of mental disorders, whereas the National Health Surveys also captured undiagnosed or unrevealed mental health problems.

The administrative data used by Black and Lee (2009) showed a substantial increase in the share of NSA recipients reporting a mental illness between 2002 and 2008 (Figure 5.3). While the authors suggested that the rise was attributable to the tightening of DSP eligibility criteria in 2006, it was more likely to have stemmed from higher rates of disclosure than from greater prevalence. A look at Figure 5.2, for example, shows that the prevalence of mental disorders among NSA beneficiaries did not change over the decade to 2012. And the fact that the share of DSP recipients reporting both mental illness and another disability also increased between 2002 and 2008 suggest that mental disorders received more attention during assessment, as in many other OECD countries (OECD, 2012). Finally, the

Welfare to Work reform of 2006 stiffened job-search obligations for a range of income support beneficiaries, which drove a higher need to reveal mental health conditions in order to benefit from job-seeking exemptions (see below).

Figure 5.3. **The incidence of mental illnesses significantly increased among both DSP and NSA recipients**

DSP and NSA recipients by mental health and/or other disability status



DSP: Disability Support Pension. NSA: Newstart Allowance.

Source: Black, D and W.S. Lee (2009), "Experiences of Income Support Recipients with a Mental Illness", Table 4.2, Project 6/2008, Prepared for the former Department of Education, Employment and Workplace Relations under the Social Policy Research Services Agreement.

StatLink http://dx.doi.org/10.1787/888933287731

Both RED data on certified mental illness among beneficiaries and health survey data on self-assessed mental health status show that the vast majority of NSA claimants with a mental illness are people who struggle with mild-to-moderate and/or a temporary mental disorder. As for DSP recipients, unsurprisingly, half were affected by more severe, enduring conditions. NSA beneficiaries with a mental disorder also tended to be much more in touch with the labour market – in that they had a stronger work ethic, higher current and past employment rates, and less welfare on reliance (Black and Lee, 2009).

The identification of mental health problems can be further improved

When they register with the Department of Human Services (DHS), jobseekers are screened to determine what type of employment services would best hasten return to employment. The DHS assessors perform the

first screening with the Job Seeker Classification Instrument (JSCI), a profiling tool that uses a statistical model to assess a jobseeker's likelihood of slipping into or remaining in long-term unemployment. The JSCI assessment score determines the intensity of services a jobseeker needs (Stream A or B; see above), and with it, the level of funding an employment service provider may receive for the jobseeker.

Jobseekers who report multiple or complex barriers to employment during their JSCI assessment (regardless of their JSCI score) can be referred for an Employment Services Assessment (ESAt). The ESAt is a comprehensive evaluation of a jobseeker's work capacity and determines whether they require intensive services within the mainstream employment provision or should be referred to a specialised disability employment service. The main difference here is the level and duration of support which a provider can offer (see below for more details).

Jobseekers who claim DSP are referred for a Job Capacity Assessment (JCA). It measures any functional impairments arising from a permanent medical condition, their current and future capacity to work, barriers to finding and holding down a job, and any intervention or assistance that may be required to help improve their current work capacity.

The Job Seeker Classification Instrument over-relies on self-disclosure of mental health issues

The JSCI is the primary profiling tool for determining a client's labour market disadvantage. The profiling is done over the telephone or face to face, either by the DHS or by an employment service provider if the jobseeker is registered with that provider. The JSCI is the earliest opportunity in the system to identify and assess the impact of a jobseeker's mental health condition on his or her past and future participation in the labour market.

However, identifying mental ill-health during the JSCI interview is not self-evident. Because answering questions related to disability or medical conditions is voluntary, people do not always disclose their mental health problem in the initial interview. To make matters worse, about 60-65% of assessments are performed on the phone according to the Department of Employment. This practice can lead to poorer-quality assessment results, since problematic behaviour or hidden barriers are less likely to be spotted over the phone than face-to-face (House of Representatives, 2012).

More need for effective identification of jobseekers' individual needs has also been repeatedly echoed by employment service associations (AASW, 2013; BoysTown, 2013; Jobs Australia, 2013; NESA, 2013) in

response to the call of the former Department of Education, Employment and Workplace Relations (DEEWR) to improve the system in 2013 (DEEWR, 2013a).

JSCI's effectiveness could be boosted through the addition of a validated mental health instrument on top of the direct question on mental ill-health. Such a move would increase the likelihood of an undiagnosed and/or undisclosed mental health problem being brought to light. Similarly, *Better Practice Guide 1* for employment service providers (DEEWR, 2013b; see Box 5.2) encourages them to improve their own assessment tools by enriching their content (to include, for instance, personal and health elements) and using standardised instruments and psychology tools to identify mental health issues that might form a barrier to work.

Box 5.2. **Better Practice Guides**

The Australian Government has made *Better Practice Guides* for employment service providers available on its website. The guides share best practice from the Innovation Fund and the Job Services Australia Demonstration Pilots which have trialled innovative methods of delivering support to disadvantaged jobseekers. The *Better Practice Guides* are divided over eight themes: assessment (*Guide 1*); case planning (*Guide 2*); jobseeker contact (*Guide 3*); case management (*Guide 4*); organisational collaboration (*Guide 5*); post-placement support (*Guide 6*); employer engagement (*Guide 7*); and social outcomes (*Guide 8*). Several of these *Better Practice Guides* are discussed later in this chapter.

Yet, it is unclear whether the *Better Practice Guides* are actively promoted across the country and to what extent employment service providers have been implementing the recommendations advocated in these guides. There has also never been an assessment of implementation and no final evaluations of the Demonstration Pilots have been published.

Source: Department of Employment (2015), Better practice guides for employment services providers, https://employment.gov.au/better-practice-guides-employment-service-providers (accessed 2 September 2015).

If providers spot a mental health problem, they may recalculate a jobseeker's JSCI score. However, only the DHS can conduct a reassessment for less intensive service streams (Streams A and B) within the first six months of a jobseeker entering the employment service system (Department of Employment, 2014b). JSCI assessments may be updated for the purpose of referring jobseekers for an ESAt interview or assigning them to a high-intensity service stream, so securing additional funding.

Few jobseekers with a mental disorder undergo Employment Services Assessment

If the JSCI indicates multiple or complex barriers to work, or providers spot additional obstacles at a later stage, jobseekers may be referred to an ESAt. The ESAt is used to determine whether the jobseeker warrants *jobactive* high-intensity service stream (Stream C) or referral to other services such as Disability Employment Services. The DHS has primary responsibility for the referral to an ESAt where the need has been identified through the JSCI. Jobseekers in Stream C of *jobactive* or in Disability Employment Services who have a change in circumstances may also be referred by their employment service provider for an ESAt.

The ESAt is a more in-depth assessment than the JSCI. It is designed to identify jobseekers' barriers to finding and keeping work, the number of hours they can work, the level of labour market participation requirements, and the type of interventions or assistance they may need to improve their current work capacity. Both medical and non-medical conditions can prompt an ESAt. Non-medical ESAts can secure more intensive support for jobseekers who, although they have no diagnosed mental health problems, show clear signs of significant barriers to work.

ESAts are conducted by DHS allied health professionals (nurses, physiotherapists, psychologists, occupational therapists, etc.) and take the form of face-to-face interviews, unless jobseekers are unable to attend because of a medical condition or other barrier. Altogether, some 20% of the 238 000 ESAts undertaken in 2012 took place over the phone, of which half were in metropolitan areas (SSCEEWR, 2013).

In 2013, jobseekers whom an ESAt identified as having a primary mental health condition accounted for 13% of the employment services' caseload. More than half (57%) were assigned to mainstream employment service providers, and the remaining 43% were serviced by specialised DES providers (Figure 5.4).

In both the (now defunct) JSA system and DES, the share of people with a mental health condition in total caseloads rose slightly between 2010 and 2013 – from 6% to 8.8% of JSA clients and from 31.4% to 34.2% in DES.

It should be noted that the share of ESAt-identified jobseekers with mental health problems was less than half of the National Health Survey's estimated prevalence of 30% of jobseekers (see Figure 5.2 above). This finding indicates that the majority of jobseekers with mental health problems do not benefit from intensive employment services.

Figure 5.4. **There are more jobseekers with mental ill-health in mainstream than in disability employment services**

Jobseekers with a mental health condition identified through the Employment Services Assessment (ESAt), 2010-13

Note: Jobseekers can have a combination of mental and physical health conditions.

Source: Data provided by the Australian Department of Social Services.

StatLink http://dx.doi.org/10.1787/888933287741

Mainstream employment services for people with mental disorders

More structured collaboration with mental health services is needed

Jobseekers identified by ESAt as suffering from a mental health condition are much more likely to receive intensive support than the average jobseeker. In 2013, of the 67 000 JSA clients with a mental disorder (8.8% of the caseload), most were assigned to the two service streams for jobseekers most in need of support – 64% to Stream 4 and 22% to Stream 3 (Figure 5.5, Panels A and B). The JSA data also showed that 44% had to contend with one or more other disadvantages – 14% were homeless, for example, 15% were ex-offenders, and 8% came from an indigenous background. As for jobseekers with a mental health problem who had not undergone an ESAt, there was no way of knowing whether they had been referred to service stream 1, 2 or 3 (stream 4 required an ESAt by definition).

As outlined above, Australia's outsourced employment service changed in July 2015 – from the JSA model with its four service streams (1, 2, 3 and 4) to *jobactive* with three service streams (A, B, and C). A jobseeker's score on the different profiling tools of the Department of Human Services (JSCI, ESAt and JCA) determines to which service stream they are assigned.

Jobseekers who are work ready are placed in service stream A, while those with the most complex, multiple barriers to employment receive more intensive services in stream C.

It is unclear, however, to which service stream jobseekers with mental health problems are to be referred under *jobactive*. Jobseeker profiles in July 2015 suggest that approximately 55% (with or without a mental health condition) will be in Stream A, 28% in B, and 17% in C (Figure 5.5, Panel A). As a result, some of the jobseekers that previously received Stream 4 services under JSA will end up in a stream that enjoys a lower level of funding than before the *jobactive* reform.

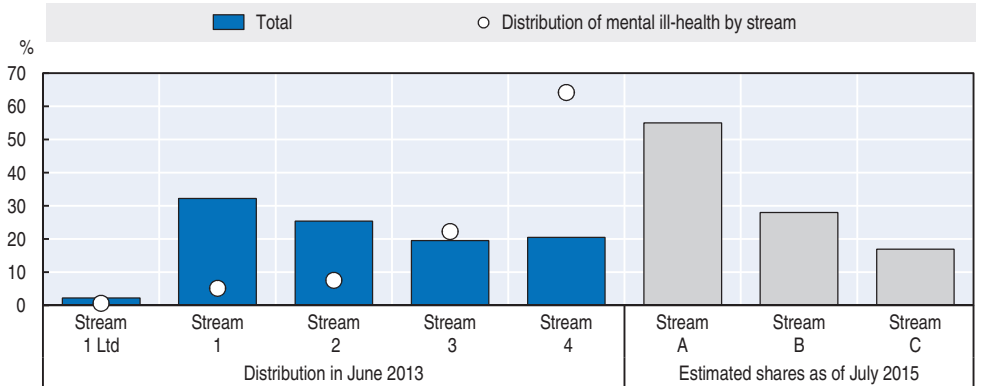
That being said, jobseekers with a mental disorder widely had less successful labour market outcomes than those without mental health problems, irrespective of the JSA stream to which they were assigned. In 2012, for instance, only 27% of the clients with a mental disorder in the Stream 2 caseload stayed in education or employment for 13 weeks, in contrast to 39% of their peers without a mental disorder (Figure 5.6). In Stream 4 (the programme for those with severe barriers to employment), the figures were 16% for those with mental disorders and 21% among those with no mental disorder. However, it is not entirely surprising that jobseekers with mental ill-health generally have less positive outcomes than their peers with good mental health, precisely because mental ill-health is an additional barrier.

One particularly interesting finding was that the difference in outcomes between jobseekers with poor and good mental health under JSA was much wider in Stream 2 than in Stream 3 and 4. Jobseekers with no mental health issues in Stream 2 were 44% more likely to complete 13 weeks in work or education than their peers with mental health problems in the same stream. The disparity narrowed to 37% in Stream 3 and 35% in Stream 4. For 26-week outcomes, the gap between Streams 2 and 3 was even greater.

These figures suggest that jobseekers with a mental disorder in Stream 2 suffered particularly from inadequate services. Since they did not have multiple employment barriers – if they had, they would be in Stream 4 – it was not deemed necessary to provide them with intensive employment services. Yet the mental health gap in outcomes also points to the need to address mental health problems more fully. If the labour market prospects of the jobseekers who suffer from mental ill-health are to be improved, there needs to be additional funding to enable employment service providers to work closely with mental health services.

Figure 5.5. **Jobseekers with a disclosed mental disorder receive more intense services than the average jobseeker**

Panel A. Distribution of jobseekers by JSA and jobactive employment service stream, 2013 and 2015



Panel B. Expenditure on jobseekers with a mental health condition from the Employment Pathway Fund split by Job Services Australia Stream, 2012-13

	2012/13	
Stream	**Expenditure (AUD)**	**Average per jobseeker (AUD)**
Stream 1	138 657	204
Stream 2	1 753 266	526
Stream 3	4 270 190	643
Stream 4	20 623 599	782
Total	27 484 090	742

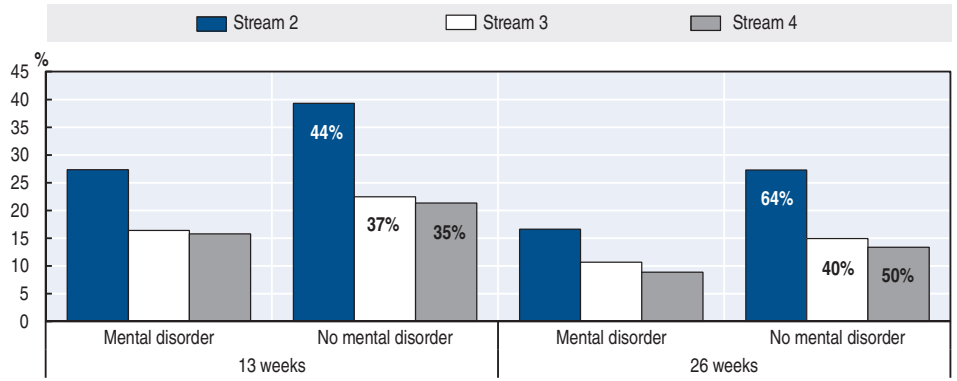
Note: The table total includes a small amount of expenditure that is not attributed to an employment service stream. Jobseekers assisted across multiple financial years are only counted once when calculating the overall average per jobseeker figure.

Source: OECD estimates based on data from Job Services Australia (Panel A) and the Employment Pathway Fund (Panel B) provided by the Australian Department of Social Services, and Department of Employment (2014), *Request for Tender for Employment Services 2015-2020*, Australian Government, Canberra.

StatLink http://dx.doi.org/10.1787/888933287753

Figure 5.6. **Jobseekers with a mental disorder are less successful in finding a job than those who have no mental disorder**

Education and employment outcomes for jobseekers in the financial year 2012/2013 as a proportion of the jobseeker caseload in June 2012



Note: Calculations compare flows in a year (the registered outcomes) with stocks at the beginning of that year (the registered caseload). As flows and stocks strictly speaking cannot be linked, this is only a proxy for the effectiveness of the system for different groups. The percentages in the bars refer to the difference in each stream in outcomes between jobseekers with and those without a mental disorder.

Source: OECD calculations based on data provided by the Department of Employment.

StatLink http://dx.doi.org/10.1787/888933287760

The Employment Fund would be an easy way to allocate additional funding for mental health support to all streams. The Employment Fund (called "Employment Pathway Fund" under JSA) is a flexible pool of funds on which employment service providers may draw to assist eligible jobseekers to build experience and skills to get and keep a job. Employment service providers can also use the Employment Fund to purchase services from a psychologist or an allied health professional for eligible jobseekers.

Providers receive credit for each jobseeker, the size of the credit being determined by the service stream. For example, under *jobactive,* AUD 300 is granted for a jobseeker in Stream A, AUD 850 for one in Stream B, and AUD 1 200 for one in Stream C (Table 5.3 below).

As long as they stay within the Employment Fund guidelines and contract provisions, providers may spend as much or as little of the credit on the individual jobseeker or group of jobseekers for whom it was awarded. An option would be to add money for mental health to the Employment Fund on which employment service providers may draw to organise integrated employment and mental health services. The importance of such

integrated services is also stressed in the recent Report of the Reference Group on Welfare Reform to the Minister for Social Services (2015).

The *Better Practice Guide 5* for employment service providers (DEEWR, 2013c; see also Box 5.2 above) encourages mainstream employment service providers to offer disadvantaged jobseekers integrated services. Interim evaluation reports of the pilot projects on which the *Better Practice Guide* was based suggested that, although engaging with external parties and building relationships takes a great deal of time, it yields significant benefits, such as faster referrals to external services, the pooling of knowledge and skills among staff, less duplication of efforts, and less frustration for the jobseeker. Most of the participating pilot providers drew up communication protocols with external organisations or invited them to participate in meetings. Less common was the inclusion of staff from other organisations in case management teams.

In the *Better Practice Guide 4* for employment service providers, the former DEEWR (2013d; see also Box 5.2 above) particularly recommends integrated employment and mental health services and argues that staff with mental health expertise can help speed up treatment for jobseekers with mental health conditions. Most of the participating pilot projects preferred support where non-vocational interventions complemented employment and job-search training.

Yet, it is unclear to what extent employment service providers have been implementing the recommendations advocated in the *Better Practice Guides*. To further foster partnerships between employment service providers and mental health services, one option could be for the Australian Government to make them mandatory in its specifications for invitations to tender. That employment service providers should be actively encouraged and given incentives to engage with other stakeholders was also one of the recommendations of the Federation of Ethnic Communities' Councils for improving the JSA system (FECCA, 2013).

The reformed system of provider fees could improve placement outcomes

Even when employment service providers manage to place their clients in a training course or job, many of them do not last beyond the 13- or 26-week placement times. Only 27% of the clients with a mental disorder in JSA's Stream 2 caseload in 2012 stayed in education or employment for 13 weeks, while just 17% managed 26 weeks. Among jobseekers with a mental disorder in Stream 4, 16% completed 13 weeks in education or employment, while the 26-week success rate was a mere 9%.

Yet of that 9% Stream 4 jobseekers, 71% of them then went on to 52 weeks (DEEWR, 2013e).

Nevertheless, outcomes were poor, which points to the need for greater funding of on-the-job support for employees and employers to increase the chances of placed jobseekers keeping their job. Underfunding is exemplified by financial year 2012-13, for example, when less than 1% of all Employment Pathway Fund expenditure on jobseekers with a mental health condition was dedicated to post-placement support (as calculated based on data provided by the Department of Employment). Jobseekers may also have been assisted in their job or educational placements through other Employment Pathway Fund categories, such as training or professional services, but no data are available of such post-placement support.

Reform of the way providers are remunerated under *jobactive* could make for more effective placement and encourage providers to invest more in post-placement support to ensure longer-term employment outcomes. While service fees accounted for nearly two-thirds of providers' revenue under JSA, outcome fees have assumed greater importance under *jobactive* and are estimated to supply 52% of revenue. Outcome fees for clients who have kept their job for 26 weeks are now a multitude of those for clients who have completed four weeks of employment, especially in Streams 3 and 4 (Tables 5.2 and 5.3). Moreover, while the JSA system did not formally define post-placement support, it is a contractual requirement under *jobactive* – though providers are free to decide how they organise it.

The former DEEWR (2013e) found, in its *Best Practice Guide 6* for employment service providers (see also Box 5.2 above), that enhanced post-placement support for jobseekers in Stream 4 helped identify and resolve problems and strengthen relationships with employers. Although the final results were not available at the time of writing, an interim evaluation of participating pilot providers who delivered continuing support (some beyond 26 weeks) reported that, after nine months in employment, 75% of jobseekers with post-placement support were still not claiming benefit, compared with 43% in the control group. The *Better Practice Guide 6* also observed that high-performing providers placed equal emphasis on the right support both for placed jobseekers and for the employers who took them on. Nevertheless, the question is to what extent the recommendations in the *Better Practice Guide 6* are being implemented by employment service providers across the country.

Table 5.2. **Job Service Australia funding model**

Fees paid to JSA providers (AUD), by jobseekers' stream

	Stream 1		Stream 2		Stream 3			Stream 4		
Service fees (yearly total)[a]	581		885		1 120			2 736		
Employment Pathway Fund[b]	11 (in Q2)		550		1 100			1 100		
Placement fees	440		550		550			550		
Outcome fees by length of unemployment[c]	<12m	>12m	<12m	>12m	<12m	12m-59m	>60m	<12m	12m-59m	>60m
at 13 weeks	-	629	743	1 032	1 560	2 228	2 940	1 560	2 228	2 940
at 26 weeks	-	629	743	1 032	1 560	2 228	2 940	1 560	2 228	2 940

a. Irrespective of a jobseeker's stream, providers receive additional service fees once the jobseeker enters the Work Experience Phase (usually after 12 months of unemployment). The maximum fee is AUD 722 per jobseeker per year and in the Compulsory Activity Phase (usually after 24 months of unemployment) AUD 398 per jobseeker per year.

b. Additional credits become available in certain cases, e.g. Stream 4 jobseekers are unemployed for more than one year (AUD 550), Streams 2-4 Early School Leavers (AUD 500), interpreter assistance (AUD 1 000), when jobseekers enter in the Work Experience Phase (AUD 500) or Compulsory Activity Phase (AUD 1 000).

c. A bonus of 20% is paid if outcomes meet the conditions set out in the Employment Services Deed Guidelines. Employment providers may receive fees for the placement of Stream A jobseekers only when the latter have spent 3 months on their rolls.

Source: Based on Department of Employment (2014), "Employment Services Deed 2012-2015", Annexure C (pp. 134-140), https://docs.employment.gov.au/system/files/doc/other/esd4_ss_-_clean_-_gdv_8_-_accessible_version.pdf (accessed 2 September 2015).

StatLink http://dx.doi.org/10.1787/888933287863

Table 5.3. ***Jobactive* funding model**

Fees in AUD paid to *jobactive* providers by service stream

	Stream A			Stream B			Stream C		
Administration fee	250			250			250		
Employment Fund	300 (in Q2)			850			1 200		
Work for the Dole (Indiviual fee)	1 000			1 000			1 000		
Outcome fees by length of unemployment	3-24m	24-59m	>60m	<24m	24-59m	>60m	<24m	24-59m	>60m
at 4 weeks	400	500	600	750	1 000	1 250	1 000	1 500	2 000
at 12 weeks	500	1 000	1 250	1 000	2 000	2 500	2 000	3 000	4 000
at 26 weeks	650	1 250	1 550	1 900	2 500	3 150	2 500	3 750	5 000

Source: Based on Australian Government (2015), *Jobactive Deed 2015-2020*, Annexure B2 (pp. 130-133), https://docs.employment.gov.au/system/files/doc/other/final_jobactive_deed_2015-2020.pdf (accessed on 3 July 2015).

StatLink http://dx.doi.org/10.1787/888933287873

A parallel employment service system for people with disabilities

In addition to *jobactive* employment services, Australia also has a Disability Employment Service for jobseekers with diagnosed disabilities, illnesses or injuries who need assistance finding and keeping jobs. There are two demand-driven programmes in DES: Disability Management Services (DES-DMS) and Disability Employment Support Services (DES-ESS).

- DES-DMS provides services to eligible jobseekers with temporary or permanent disability, injury or health condition who require the assistance of a DES provider but who are not expected to need regular, long-term support in the workplace.
- DES-ESS is available to those eligible jobseekers with a permanent disability who are assessed as needing regular, long-term ongoing support in the workplace. There are two service streams within DES-ESS, with different funding levels depending on the needs of the jobseeker.

Eligibility for DES is determined through an ESAt or a JCA, which also assigns jobseekers to DES-DMS and the suitable DES-ESS stream. However, there are no clear referral rules, with assessors deciding on a case-by-case basis whether to refer a jobseeker with a mental health condition to a DES or *jobactive* provider. As Figure 5.4 shows, ESAt assessors refer more than half (57%) of the jobseekers whom they identify as suffering from a mental health condition to a mainstream provider. Within DES, there are as many jobseekers with mental conditions supported by DMS as by ESS (about 25 000 each in 2013). The total DES caseload was about 150 000 in 2013 (equally divided between DMS and ESS), compared with about 760 000 under JSA.

The Australian Government funds DES providers to a much higher level than their *jobactive* counterparts in order to enable more intensive capacity-building interventions, health rehabilitation services, job preparation, and on-going support in the workplace. Funding is also more outcome-focused in DES. Outcome fees account for about 70% of DES providers' revenue – more than in JSA or even *jobactive* – and they are entitled to significant on-going support fees, which may run beyond the 26 weeks of employment, in order to strengthen placed jobseekers' chances of keeping their job (Table 5.4). The services jobseekers with a mental health condition receive thus depend on whether they are assigned to *jobactive* or DES. In the financial year 2012-13, spending per jobseeker under JSA (including Employment Pathway Funds but excluding wage subsidies) was about 40% of the amount DES spends per jobseeker.

Table 5.4. **Disability Employment Service funding model**

Fees paid to DES providers (AUD), by type of service

	DES-DMS	DES-ESS	
		Level 1	Level 2
Service fees[a]	715	890	1 900
Placement fees	770	770	1 540
Full outcome fees[b]			
At 13 weeks	2 860	2 860	5 500
At 26 weeks	4 400	4 400	7 700
Ongoing support fees[c]			
Basic	440	440	440
Moderate	-	1 320	1 320
High	-	3 300	3 300

DES-DMS: Disability Employment Services – Disability Management Service. DES-ESS: Disability Employment Services – Employment Support Service.

a. Service fees are paid every 13 weeks, up to a maximum 8 times. In DES-DMS, the fee is AUD 1 595 for the first and second 13-weeks periods.

b. A bonus of 20% is paid if the outcomes meet the conditions set out in the guidelines.

c. Basic on-going support fees are paid maximum 6 times in 26 weeks. Moderate to high on-going support fees are paid every 13 weeks, without limit in time.

Source: Department of Social Services (2015), "Disability Employment Services Deed", Annexure B (pp. 166-171), https://www.dss.gov.au/sites/default/files/documents/03_2015/des_deed.pdf (accessed 2 September 2015).

StatLink http://dx.doi.org/10.1787/888933287881

The higher DES funding level clearly pays off, especially for jobseekers with a mental health condition. The employment and education outcomes of JSA Stream 4 clients were inferior to those of DES clients, despite the fact that the latter are supposed to be more disadvantaged (Figure 5.7). In financial year 2012-13, some 20% of DES-DMS participants and 27% of DES-ESS participants with a mental health condition were in employment or education for 13 weeks, compared with only 16% of the JSA Stream 4 caseload with mental health conditions.

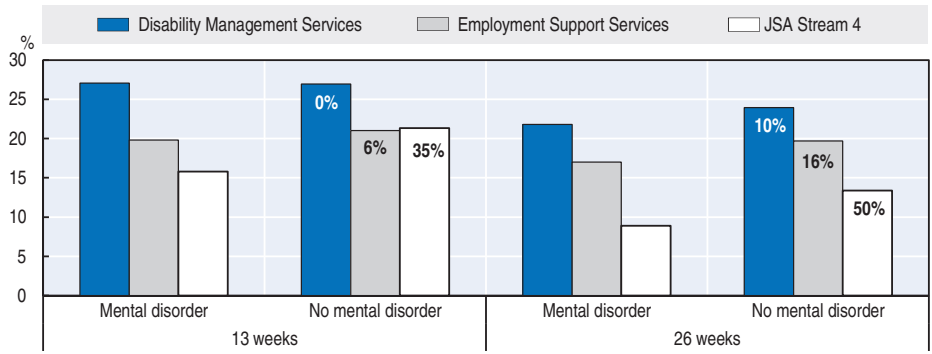
Furthermore, thanks to DES on-going support services, their clients with a mental health condition were much more likely than their peers without mental health conditions in JSA Stream 4 to keep their job for 26 weeks. Indeed, the conversion rates to 52 weeks were 80-85% with DES and 56% under JSA.

Finally, after a 13-week placement there was hardly any difference in the DES system between the outcomes of jobseekers with a mental health

condition and those without. Jobseekers with mental health conditions in JSA Stream 4, by contrast, showed outcomes that were 35% worse than their peers without mental health conditions – and the disparity widened to 50% by week 26 (Figure 5.7).

Figure 5.7. **DES clients have better outcomes than JSA clients**

Employment and education outcomes as a proportion of the caseload and percentage difference in outcomes, 2012-13



DES: Disability Employment Services. JSA: Job Services Australia.

Note: The percentages in the bars refer to the difference in outcomes between those with and without mental problems and in each service provision.

Source: OECD calculations based on data provided by the Department of Employment.

StatLink http://dx.doi.org/10.1787/888933287778

These differences in outcome between JSA Stream 4 and DES call for significant revision of the services offered by mainstream providers to jobseekers with mental health problems. While reform and the switch to *jobactive* may have some positive effects on on-the-job support for jobseekers with mental health problems, additional funding will be needed to achieve outcomes comparable with those of DES providers. At the same time, the question arises as to whether there is really any need to differentiate between mainstream services and disability services.

Many unemployed Australians do not receive employment services

Aside from failing in the employment service provision for people with mental ill-health, too many of them do not actually benefit from any employment services for two main reasons:

1. because they do not qualify
2. because they are exempted or suspended from participation requirements.

Very limited services are available to jobseekers without income support

As pointed out in the forthcoming OECD report, *Back to Work: Australia. Improving the Re-employment Prospects of Displaced Workers*, the Australian employment service system is such that jobseekers who do not have access to income support receive little or no employment services. Although between 51% and 64% of the unemployed people who suffer from mental ill-health benefitted from income support between 2001 and 2013 (Table 5.1), only 38% received NSA, YA, PP or DSP within one year of unemployment.

Such low coverage after a year of unemployment suggests that most of the newly unemployed people do not qualify, at least not immediately, for income support (or, therefore, for employment support) when they lose their job.

Under the JSA system, employment service providers were paid only a small fee for jobseekers who had no income support entitlement but voluntarily registered with a provider. In such cases, providers would offer some basic support, such as drafting a CV, advice about the local labour market and available training programmes, and instructions for the use of self-help job-search facilities. Under *jobactive*, employment service providers enjoy slightly higher funding, but only after a waiting period of three months and for no longer than three months.

The lack of or delay in access to employment services can be particularly detrimental people with mental ill-health, as their condition exposes them to a higher risk of long-term unemployment. Indeed, time is a critical factor in helping people back to work after sickness absence, enforced redundancy, job loss, and inactivity (OECD, 2015). The longer workers with mental ill-health are away from the job market, the less likely they are ever to return, since unemployment may further worsen their condition. Conversely, work can be a key factor in recovering wellbeing and self-esteem.

Ideally, the *jobactive* three-month service provision should be used to identify barriers to reactivation – which includes mental disorders – and to allocate additional resources to providers for addressing those barriers. Providers would thus be able to give early support to jobseekers who are not entitled to income support and at a high risk of long-term unemployment (and future benefit dependency).

Many jobseekers are exempted from their activation requirements

Over the past decade, the Australian welfare system has undergone considerable changes intended to encourage active workforce participation and balance participation requirements with individual abilities. To receive benefit payments, unemployed persons must:

- Actively seek work or undertake activities that improve their employment prospects;
- Accept suitable paid employment, including part-time and casual work;
- Attend interviews with the department of human services and their employment service provider;
- Enter an employment pathway plan that identifies individual vocational goals and creates an action plan to reach these goals if requested to do so.

Failure to comply with the requirements may lead to temporary or permanent disqualification from their benefits.

Under *jobactive*, activation requirements are even more stringent. Employment providers monitor jobseekers' efforts to find work and most jobseekers will be required to spend six months per year undertaking activities such as the Work for the Dole voluntary scheme or other approved activities.[2] And sanctions in the event of non-compliance have been stiffened.

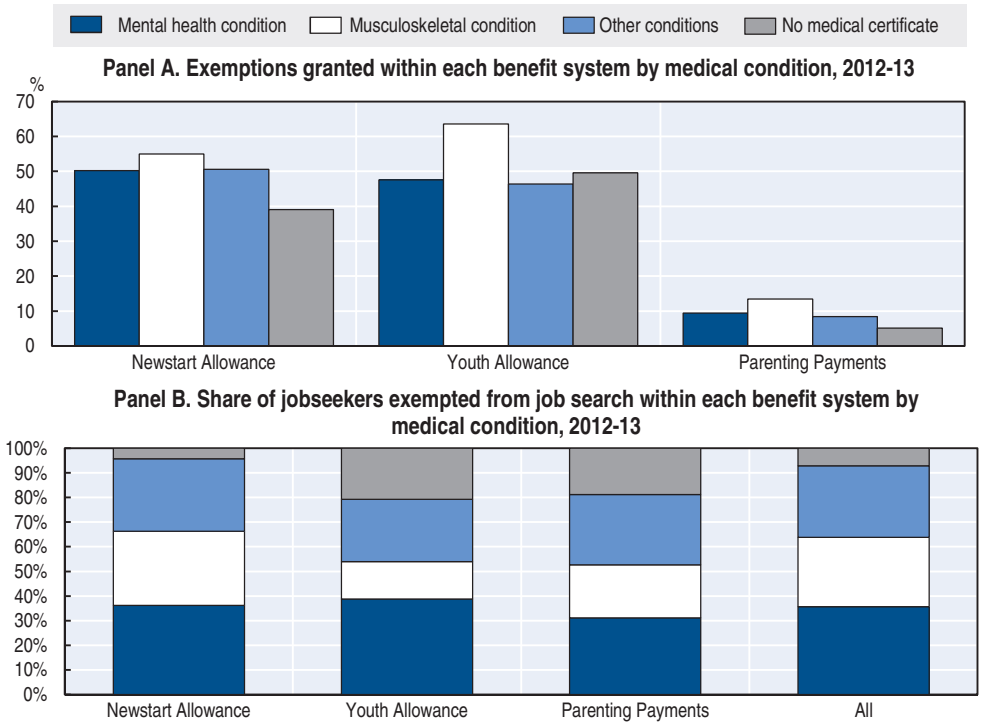
Nevertheless, there are exemptions which recognise that benefit recipients may be prevented from job searching or training for reasons such as temporary illness, injury, disability, caring responsibilities, or special circumstances like pregnancy, major personal crises, or domestic violence.

While some exemptions are automatic, such as in the case of domestic violence, a jobseeker must provide DHS with an approved medical certificate completed by a doctor stating diagnosis and prognosis to apply for an exemption for reasons of temporary incapacity. The certificate should state that the person is unable to work any more than 8 hours per week and for how long. Jobseekers applying for exemption may be referred for an ESAt, but only if they are deemed to have multiple or complex barriers to employment that require further assessment. There are no data available on how often exempted jobseekers are referred for an ESAt.

The Department of Employment's Research and Evaluation Database (RED) contains information on job-seeking exemptions for jobseekers in JSA and DES programmes. It shows that, in 2012-13, 50% of Newstart Allowance beneficiaries were exempted from job-seeking requirements on medically certified mental health grounds. The share rose to 55% among

NSA beneficiaries with a physical condition (Figure 5.8, Panel A). Even among unemployment benefit beneficiaries without a medical condition exemption rates can be high: 39% of NSA and 50% of Youth Allowance recipients. As for Parenting Payment, both single and partnered, exemption rates are low, as eligibility is restricted to parents with children under the age of 6 years old with childcare responsibilities. Finally, around 36% of all exemptions granted in 2012-13 across all benefit systems were for jobseekers with psychological psychiatric conditions. The share was highest among YA claimants (39%) and lowest among PP beneficiaries (31%) (Figure 5.8, Panel B).

Figure 5.8. **Half of all NSA and YA beneficiaries with mental health problems are exempted from job seeking**



Note: Jobseekers are deemed to have a special category of medical condition if they present a medical certificate to that effect to the Department of Human Services at any point in that year. Exemptions granted to jobseekers with multiple conditions may be counted several times and jobseekers may be granted multiple exemptions within any one year. If a jobseeker has an exemption that is longer than two years, the exemption is counted in only one year.

Source: OECD calculations based on tabulations of the Research and Evaluation Database provided by the Australian Department of Social Services.

StatLink http://dx.doi.org/10.1787/888933287787

The DHS decides how long exemptions last according to the reason for requesting them – e.g. 13 weeks for temporary incapacity. Any extension period requires a new medical certificate, the only exceptions being jobseekers who are seriously ill. Those who suffer from mental disorders are considered seriously ill if they are receiving treatment in an institution and may extend their exemption periods for up to 52 weeks without having to produce additional medical certificates. Estimates based on RED data put at some 40% the proportion of mentally ill NSA beneficiaries granted two or more exemptions in 2012-13, and at 12% those who received more than four. The incidence of multiple exemptions is very similar among NSA beneficiaries with other medical conditions.

In addition to the exemptions granted by the DHS, employment service providers can suspend jobseekers from their active caseload. Suspension is a temporary waiving of activation obligations when, although a client is registered with a provider, he or she is not actively engaged and the provider receives no fee. Generally clients are suspended when the DHS grants them an exemption or when they have a "provisional exit", e.g. a client is in employment, but has not yet completed their 13- or 26-week placement. Jobseekers with health problems who have not been exempted by the DHS can also be suspended. Data for 2011 show that 22% of the JSA caseload – 165 000 out of 760 000 jobseekers – were suspended (SSCEEWR, 2012). Of those, nearly 60 000 (8% of the caseload) were suspended for health reasons, of whom half had also been granted DHS exemptions.

The main drawback of exemptions and suspensions for health reasons is that jobseekers may not benefit from employment services (unless they voluntarily opt to participate). New jobseekers to whom the DHS grants a medical incapacity exemption longer than six weeks are generally not referred to an employment service provider until the end of their exemption. If a jobseeker is already enrolled with a provider at the time of exemption, they are suspended from the services and not required to participate in job-seeking activities until the exemption is over.

While an exempted or suspended jobseeker continues to receive unemployment benefit, the employment service provider does not receive a fee for that jobseeker (unless the jobseeker voluntarily participates). As a result, there are little or no incentives for providers to serve exempted or suspended jobseekers. For clients with mental health problems who have been placed in employment, such suspension could be problematic, since they may need post-placement support to be able to keep the job.

Since there is no limit to the total length of exemptions, jobseekers with mental health problems may easily be left to their own devices for long periods, and even for years. JSA caseload data for 2013 showed that, due to

exemptions, jobseekers with a mental health condition spent 21% less time being serviced by a provider or looking for work than their peers with no mental health conditions. Their ability to find and sustain employment suffers as a result.

Temporary incapacity to work because of mental illness should be no reason for employment service providers to suspend their services. On the contrary, research has shown that employment and mental health are interlinked: work hastens recovery, while delaying support makes it harder to get back into the labour market. That finding is further confirmed by a statement on the health benefits of work from the Royal Australasian College of Physicians (2010) and repeated in the Report of the Reference Group on Welfare Reform to the Minister for Social Services (2015). The National Employment Services Association, too, notes that suspending assistance is counterproductive (NESA, 2013).

It is important to refer all exempted jobseekers to an employment service provider and keep all those who are suspended on the caseload. Ideally, employment service providers should collaborate closely with mental health services to deliver joint services to exempted or suspended jobseekers to hasten recovery and reactivation. Providers should receive sufficient funding for such co-operation.

Recent reforms in the disability support pension system

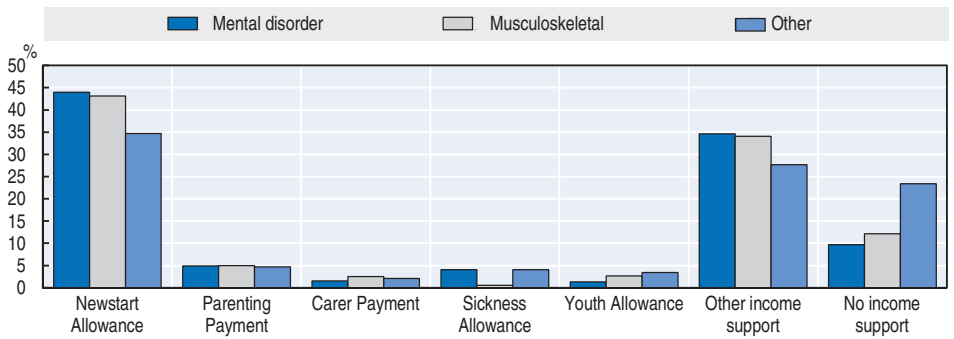
Some unemployed people with mental health problems do not claim or stay on unemployment benefit (NSA, YA or PP), but apply for Disability Support Pension (DSP) which caters for people with very low or no work capacity. RED data show that around 40% of new DSP claimants come from NSA, with the figure rising to 44% when it comes to mental disorders (Figure 5.9). DSP payments are higher than NSA and afford better protection insofar as entitlement is generally not tied to any activation requirements. However, DSP is also problematic in that it tends to be a dead end – once people are on disability benefit they hardly ever return to the labour market (OECD, 2010). And disability benefit may not always shield people from poverty in Australia (Figure 5.1 above).

DSP is a payment made to people with a permanent physical, intellectual or psychiatric impairment which attracts at least 20 points under the impairment tables (see below for a discussion on the impairment tables). The person must also be assessed as not being able to work at least 15 hours at or above the minimum wage – independent of a programme of support – and cannot be re-skilled for any work for at least the next two years (referred to as the "two-year rule" later in this chapter).

Eligibility requires that the health condition should have been fully diagnosed by a qualified medical practitioner, fully treated and stabilised, and likely to persist for more than two years (Minister for Families, Housing, Community Services and Indigenous Affairs; 2011). People with disabilities should seek and accept "reasonable" treatment – i.e. treatment that is available at a reasonable cost and distance, can be reliably expected to yield substantial improvement in the person's functional capacity, has a high success rate, and is of low risk. If someone decides against proceeding with reasonable treatment, they are barred from DSP.

Figure 5.9. **New DSP entrants with a mental disorder are more likely to have a history of income support than those with other health problems**

Proportion of new entrants to DSP by type of previous income support and health condition, 2012-13



Note: The data show new DSP entrants (or new DSP episode entrants) classified by the last income support payment previously received. It may be a direct transfer to DSP from that payment or there may have been a time lag in between benefits. "Other income support" includes the re-entry of suspended DSP grants.

Source: Department of Employment Research and Evaluation Database.

StatLink http://dx.doi.org/10.1787/888933287793

To assist the DHS in determining DSP eligibility, a Job Capacity Assessment (JCA) evaluates a person's level of functional impairment, current and future work capacity, and barriers to finding and keeping employment. JCAs are conducted by appropriately trained health and allied health professionals – usually in a face-to-face appointment at a DHS service centre, but sometimes over the phone or through a video conference.

In the past decade, a number of reforms have sought to halt the growth in DSP claims. As mentioned in Chapter 1, the disability benefit rate grew from 4.2% in the mid-90s to 5.5% in 2013. The Welfare to Work reform in 2006 was the first big step towards transforming a passive disability benefit

system into an active labour market programme. Its main thrust was to make eligibility dependent on a person's ability to work, not on their inability. To that end it extended job-seeking and employment support for DSP recipients, and shifted people with partial work capacity onto unemployment benefit combined with appropriate participation requirements (OECD, 2007). Additional reforms have come into effect more recently with increased activation obligations for DSP recipients and tighter eligibility criteria to restrict access to new claimants. Reforms are not confined to new DSP claimants, however, but to some recent beneficiaries and specific groups, too.

Increased activation for new and current DSP recipients

Two major reforms have been implemented in the past few years to reactivate DSP recipients. The first was a generous move in July 2012 that introduced rules to encourage recipients to take up work without fear of losing their pension. Even though the number of hours that they are allowed to work (15 per week) was already more generous than in other OECD countries (OECD, 2003), the limit was further increased to 30 hours. What's more, if a DSP recipient works more than 30 hours a week, their DSP is not cancelled, but suspended for up to two years without them having to reapply for DSP should their employment cease.

The shortage of recent data makes it unclear whether the new rules have increased labour market participation among DSP recipients. However, administrative data for the financial year 2009-10 show that 500 DSP recipients had their benefit cancelled because they worked more than 15 hours, while 330 had it stopped because they had worked over 30 hours. These numbers are tiny when seen against DSP's 800 000 claimants (in July 2010), which suggest very low uptake. That uptake should be so low is surprising, because the generous taper rates and the low average effective tax rates make it financially worthwhile to work (OECD, 2010).

The second measure introduced participation requirements in July 2014 for DSP recipients under 35 years of age with an assessed weekly work capacity of eight hours or more. Providers will develop with such clients a participation plan that grooms them for work and helps them find and keep it. The plan comprises voluntary activities like Work for the Dole, job hunting, the use of work experience, education and training courses, and liaising closely with a Disability Employment Service. Exactly what they are required to do varies according to their circumstances, but they must focus on finding work. It is expected that 20 000 current DSP recipients and 5 000 new recipients each year will have to meet such compulsory participation requirements. Future evaluations will have to establish whether or not this new measure improves reactivation.

However, unless the new participation requirements for DSP recipients are coupled with intensive support from a disability employment service, it is unlikely that many DSP recipients will ever return to work. RED data reveal that 7% of DSP claimants (and 4% of those with a mental disorder) came off DSP in the financial year 2013-14, though it was mostly because they had died or transferred their DSP to old-age pension. The experience of other OECD countries, too, is that it proves extremely difficult to bring people on disability benefit back into the workforce (OECD, 2015). Indeed, people who suffer from mental ill-health struggle particularly to return to sustainable employment, as their motivation and self-confidence are so low that reactivating them is costly.

Tighter eligibility criteria for new and recent DSP claimants

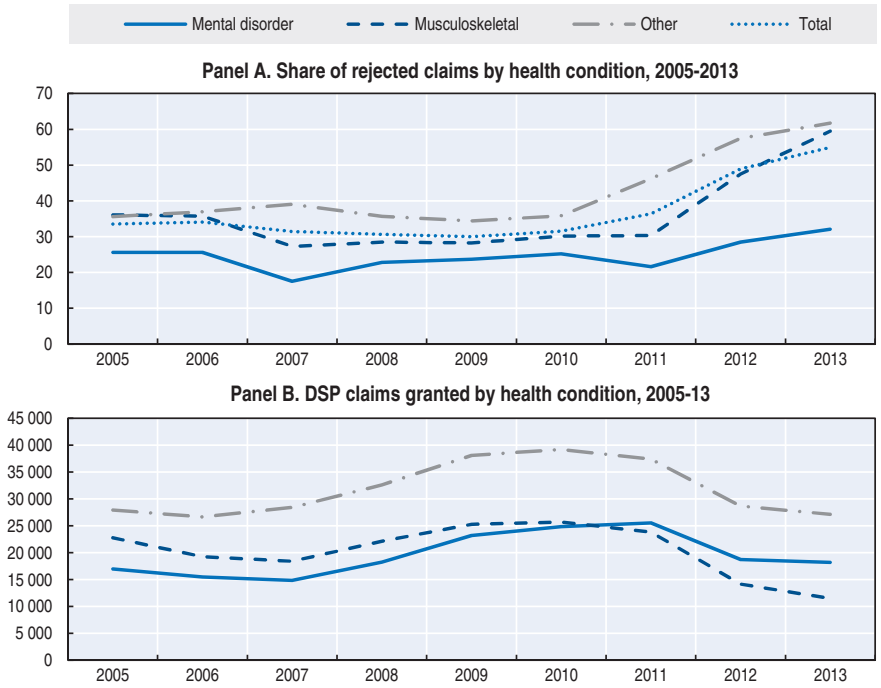
Like many other OECD countries, Australia has taken action to improve the assessment of new claims for DSP. Since January 2015, the primary source of medical evidence for DSP is no longer a certificate drawn up by the claimant's treating doctor for the purpose of claiming DSP. Instead, a government-contracted doctor now conducts a disability medical assessment to check the medical evidence supplied by the DSP claimant.

Reform also saw the revision of the impairment tables in January 2012 to better reflect contemporary medical and rehabilitation practices. The tables are function- rather than diagnosis-based and intended to assess the loss of functional capacity that affects a person's ability to work. To be eligible for DSP, a person must have a permanent physical, intellectual or psychiatric impairment assessed at 20 points or more based on the impairment tables.

The advisory committee tasked with reviewing the impairment tables felt that reform could prompt a general downward trend in scores and, as a result, fewer people would be eligible for DSP (Advisory Committee, 2011). Administrative data on DSP claim denials confirm that there has been a drop in eligible claimants since the new tables were introduced and that claims have dropped for all health conditions (Figures 5.10, Panels A and B).

However, the impact of the new impairment tables is much less pronounced when it comes to people with mental health conditions, as the advisory committee had expected (Advisory Committee, 2011). The committees anticipated that new claimants with a mental disorder would show slightly lower scores in the new impairment tables, but that they would continue meeting the eligibility criteria.

Figure 5.10. **The introduction of the new impairment tables in 2012 curbed numbers of new claimants, but with less effect on mental disorders**



DSP: Disability Support Pension.

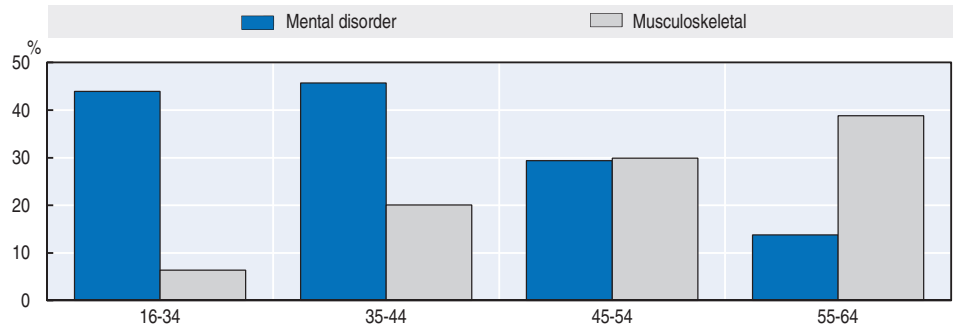
Source: Department of Employment Research and Evaluation Database.

StatLink http://dx.doi.org/10.1787/888933287808

The new impairment tables have not been used solely to assess DSP claimants; they are also applied to DSP recipients. As part of its 2014-15 budget, the government announced additional reviews, between July 2014 and December 2015, of around 28 000 DSP recipients under 35 who were granted DSP between 1 January 2008 and 31 December 2011. These people will have had their DSP eligibility reviewed against the revised impairment tables. Nearly half of all DSP grants in the under 35 age group are on the grounds of a mental disorder (Figure 5.11). Those who no longer meet the 20-point criteria, or are able to work 15 hours or more a week, will have their DSP cancelled and need to find work and/or apply for alternative income support. DSP recipients who are found to have a work capacity of eight hours or more a week will be required to take part in a participation plan (see above) while receiving DSP. Again, no data are yet available on the number of recipients who have lost their eligibility since the criteria were revised.

Figure 5.11. **Nearly half of the new claims from under-35s are granted for reasons of mental disorders**

DSP claims granted between 2008 and 2013, by health condition and age category



Source: Department of Employment Research and Evaluation Database.

StatLink http://dx.doi.org/10.1787/888933287814

As stressed above, it is essential that people who lose their disability benefit entitlement should be given intensive job-seeking support. The impact of DSP reforms on the capacity of the Disability Employment Services should not be underestimated, however, as they may generate a significant increase in their caseload.

Clearly, reassessment of the under-35s does not go far enough. Indeed, reassessments in general should be strengthened to counteract the somewhat arbitrary two-year rule used to determine DSP entitlements. The rule is particularly problematic when it comes to mental disorders, which can change fast. While income and assets tests are regularly repeated, reassessments of DSP eligibility are less comprehensive. As a result, people with mental disorders who recover after two years are unlikely to reintegrate into the labour market. In other OECD countries, like Austria, the Netherlands and the United Kingdom, only permanent conditions lead to disability benefit entitlement (OECD, 2010).

Altogether, there have been many efforts over the past decade to halt or reverse the rise in DSP claims. Some reforms have had some effect – though not when it comes to those with a mental disorder. Generally speaking, little is known about whether people who can no longer claim DSP, or who have it cut off, successfully transition into the labour market or onto another benefit.

Round-up and recommendations

Australia is one of the few OECD countries that gather mental health information on benefit claimants. That being said, actually identifying mental ill-health in the initial screening interview (JSCI) is no easy matter, as claimants can choose not to answer questions on their medical condition, and the majority of interviews are conducted over the phone. As a result, people do not always disclose their mental health problems and any problematic behaviour is unlikely to be picked up. Only people who have multiple or complex barriers to employment, or are affected by a diagnosed disability, are referred to a more comprehensive employment service or for job capacity assessment (e.g. ESAt or JCA).

Assessments assign jobseekers to employment service streams, with the more intensive streams for complex needs being granted higher funding levels. Only jobseekers whom the ESAt or JCA deem mentally ill are likely to receive intensive support – either from the mainstream employment services' high-intensity streams (Stream C under *jobactive* or Streams 3 and 4 under JSA) or, if they have a diagnosed disability, from the better-resourced special disability employment system. Most jobseekers are assigned to the low-intensity employment service stream (*jobactive's* Stream A or JSA's Streams 1 and 2).

Overall, interventions by service providers do produce less positive employment and education outcomes for jobseekers with a mental health condition than for their peers without such a condition. And differences in outcomes are particularly wide in the low-intensity mainstream service streams. However, disability employment services achieve better and longer-term outcomes with more disadvantaged clients, because they enjoy better resources and focus strongly on post-placement support.

The findings call for a significant revision of the organisation and funding of the mainstream employment services for jobseekers with mental ill-health. Reform should particularly seek to integrate employment and mental health services for this group, regardless of whether jobseekers are in high- or low-intensity streams.

To compound matters, too few jobseekers with mental health problems can access adequate employment services. Strict means testing rules many of the jobless out of income support and, as a result, they do not qualify for employment services.

Moreover, those who are entitled to employment services but produce a medical certificate from their treating doctor may often be exempted from participation requirements, possibly for a long time. During that time, however, they receive no support from their employment service provider;

many are not even referred to one. What is more, service providers can temporarily suspend client from their active caseload on mental health grounds. Yet jobseekers with mental issues are the ones most exposed to long-term unemployment and most likely to suffer from a lack of or delay in services. And the longer they are out of the job market, the less likely they are ever to return.

Some Australians with more severe, enduring mental health conditions may claim DSP, a less active, more secure long-term payment. A number of reforms in the past couple of years have sought to stem growing numbers of new DSP claimants. One measure was the introduction of new impairment tables and, more recently, greater efforts have gone into reactivating DSP recipients. Yet, unless new participation requirements are coupled with intensive support from the Disability Employment Service, it is unlikely that such recipients will ever return to work.

It is a challenge to provide the right level of support to jobseekers with mental ill-health, thereby helping them back into the labour market and avoiding permanent exit. Although Australia has many excellent features in its benefit and employment services system, the system would deliver better outcomes if a number of shortcomings were addressed.

Improve the early identification of mental health problems

- *Add a validated mental health instrument to the JSCI.* Rather than relying on jobseekers to disclose any mental health problems they might have, the DHS could introduce a validated mental health instrument that would help produce a more accurate assessment of the actual employment barriers that mental ill-health creates.
- *Ensure that all assessments are of high quality.* The structure, sequence and frequency of assessments have changed repeatedly in the past ten years. It is essential that assessments are continuously monitored to ensure they are of high quality and client-oriented. The extensive use of telephone assessments, for example, should be questioned.
- *Strengthen DSP eligibility reassessments.* The DSP eligibility two-year rule is arbitrary. Without thorough reassessments, people who recover (at least partially) will not be reactivated. Reassessments need to be strengthened to prevent DSP from becoming a dead end for claimants with temporary mental disorders. Australia could consider emulating other OECD countries and grant disability benefits only to those with permanent conditions.

Foster an integrated mental health and employment service provision

- Make collaboration between employment and mental health services mandatory. To stimulate co-operation between employment service providers and mental health services, companies tendering for employment service contracts should be required to form partnerships with mental health services. Until a new tendering process starts, the government should seek to foster integrated employment and mental health services. It could, for example, block-fund employment service providers (in function of their total caseload) who have struck formal agreements with a mental health provider so that they can purchase its services.
- *Build mental health knowledge among employment service providers.* Psychological training and clear guidelines for their caseworkers on what to do when mental health problems arise could improve service delivery.

Improve access to employment services for all jobseekers suffering from mental ill-health

- *Delink benefit eligibility from employment support.* Jobseekers at high risk of long-term unemployment should be identified as soon as they register with the DHS and referred to an employment service provider. The allocation to service streams should not dependent on the jobseekers income support entitlement. Such a practice would require initial investment in employment services which would pay off in the medium term.
- *Ensure integrated mental health and employment services for jobseekers who present a mental health medical certificate.* Rather than exempting or suspending jobseekers with mental health problems from employment services, they should be offered appropriate services to hasten their recovery and reactivation. Treatment and close co-operation between employment service providers and mental health services should be an integral part of re-employment plans.

Encourage post-placement support to ensure longer-term employment outcomes

- *Eliminate the suspension option.* The current practice of suspending jobseekers from the active caseload if a placement is expected to lead to employment discourages post-placement support.

- *Allocate on-going support funds to jobactive providers.* Post-placement support helps increase the likelihood that jobseekers with mental health problems stay in work or education beyond the 13- or 26-week placement period. While *jobactive* pays outcome fees, which may encourage mainstream employment service providers to offer some on-the-job support, it will probably have to offer additional funding if providers are to achieve outcomes comparable to those of DES providers.
- Make better use of the *Better Practice Guides.* Publish the final evaluations of the projects that participated in the Innovation Fund and the Job Services Australia Demonstration Pilots, and distribute the results to the public. Actively promote the recommendations advocated in these guides to employment service providers across the country and introduce incentives to encourage their implementation, possibly linking it with the star-rating system used to assess the quality of employment services.
- *Consider merging the jobactive and DES systems.* The reluctance to change historical structures is understandable. Yet the whole system of employment services would benefit from a stronger client focus. The government should consider whether there is really a need to differentiate between mainstream and disability services.

Better support DSP recipients in their re-activation

- **Scale up resources for DES providers**. Reforms to the DSP system are likely to prompt a steep rise in the number of clients that DES providers will have to serve. The government should closely follow the trend and allocate additional resources accordingly.

Notes

1. Jobseekers are identified as having a medical condition if they have presented a medical certificate identifying that condition to the Department of Human Services at any point in the year.
2. The Work for the Dole programme requires unemployed individuals to work for not-for-profit organisations and government agencies in order to receive welfare benefits.

References

AASW – Australian Association of Social Workers (2013), "Employment Services – Building on Success", *Issues Paper*, Department of Education, Employment and Workplace Relations, Australian Association of Social Workers, Canberra.

Advisory Committee (2011), "Review of the Tables for the Assessment of Work-Related Impairment for Disability Support Pension", Final Report, Submitted to the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs.

Australian Government (2015a), *Guide to Social Security Law*, Version 1.215, Released 21 September 2015, http://guides.dss.gov.au/guide-social-security-law (accessed 28 September 2015).

Australian Government (2015b), *Jobactive Deed 2015-2020,* Annexure B2 pp. 130-133, https://docs.employment.gov.au/system/files/doc/other/final_jobactive_deed_2015-2020.pdf (accessed on 3 July 2015).

Black, D. and W.S. Lee (2009), *Experiences of Income Support Rrecipients with a Mental Illness*, Project 6/2008, prepared for the Department of Education, Employment and Workplace Relations under the Social Policy Research Services Agreement.

BoysTown (2013), *Response to Department of Education Employment and Workplace Relations Issues Paper, Employment Services: Building on Success*, BoysTown, Brisbane.

Butterworth, P. (2003), "The Prevalence of Mental Disorders Among Income Support Recipients: An Important Issue for Welfare Reform", *Australian and New Zealand Journal of Public Health*, Vol. 27, No. 4, pp. 441-448.

DEEWR – Department of Education, Employment and Workplace Relations (2013a), "Employment services – building on success", *Issues Paper*, Department of Education, Employment and Workplace Relations Australian Government, Canberra.

DEEWR (2013b), *Better Practice Guide 1 – Assessment*, Department of Education, Employment and Workplace Relations Australian Government, Canberra.

DEEWR (2013c), *Better Practice Guide 5 – Organisational Collaboration*, Department of Education, Employment and Workplace Relations Australian Government, Canberra.

DEEWR (2013d), *Better Practice Guide 4 – Case Management*, Department of Education, Employment and Workplace Relations Australian Government, Canberra.

DEEWR (2013e), *Better Practice Guide 6 – Post-placement Support*, Department of Education, Employment and Workplace Relations Australian Government, Canberra.

Department of Employment (2015), "Better Practice Guides for Employment Services Providers, https://employment.gov.au/better-practice-guides-employment-service-providers (accessed on 5 September 2015).

Department of Employment (2014a), *Request for Tender for Employment Services 2015-2020*, Australian Government, Canberra.

Department of Employment (2014b), *Employment Services Deed 2012-2015*, Annexure C, pp. 134-140. https://docs.employment.gov.au/system/files/doc/other/esd4_ss_-_clean_-_gdv_8_-_accessible_version.pdf (accessed on 3 July 2015).

Department of Social Services (2015), *Disability Employment Services Deed*, Annexure B, pp. 166-171, www.dss.gov.au/sites/default/files/documents/03_2015/des_deed.pdf (accessed on 3 July 2015).

FECCA – Federation of Ethnic Communities' Councils of Australia (2013), "FECCA Submission to 'Employment Services – Building on Success' Issues Paper", Federation of Ethnic Communities' Councils of Australia, Deakin.

House of Representatives (2012), *Work Wanted: Mental Health and Workforce Participation*, Standing Committee on Education and Employment, House of Representatives, The Parliament of the Commonwealth of Australia, Canberra.

Jobs Australia (2013), "Response to the 'Employment Services – Building on Success' Issues Paper", Victoria.

Kiely, K. and P. Butterworth (2013), "Mental Health Selection and Income Support Dynamics: Multiple Spell Discrete-time Survival Analyses of Welfare Receipt", *Journal of Epidemiology and Community Health*, Vol. 0, pp. 1-7.

Minister for Families, Housing, Community Services and Indigenous Affairs (2011), "Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination 2011", Social Security Act 1991.

NESA – National Employment Services Association (2013), "Realising our Potential, Response to 'Employment Services – Building on Success' Issues Paper", National Employment Services Association, South Melbourne.

OECD (forthcoming), *Back to Work: Australia. Improving the Re-employment Prospects of Displaced Workers*, OECD Publishing, Paris.

OECD (2015), *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264228283-en.

OECD (2012), *Activating Jobseekers: How Australia Does It*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264185920-en.

OECD (2010), *Sickness, Disability and Work: Breaking the Barriers: A Synthesis of Findings across OECD Countries*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264088856-en.

OECD (2007), *Sickness, Disability and Work: Breaking the Barriers (Vol. 2): Australia, Luxembourg, Spain and the United Kingdom*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264038165-en.

OECD (2003), *Transforming Disability into Ability: Policies to Promote Work and Income Security for Disabled People*, OECD Publishing, Paris, http://dx.doi.org/10.1787/9789264158245-en.

Report of the Reference Group on Welfare Reform to the Minister for Social Services (2015), "A New System for Better Employment and Social Outcomes", Commonwealth of Australia, February.

SSCEEWR – Senate Standing Committee on Education Employment and Workplace Relations (2013), "Questions on Notice, Additional Estimates 2012-2013: DEEWR Question No. EW0874_13: Job Capacity Assessments", Senate Standing Committee on Education Employment and Workplace Relations, Canberra, www.aph.gov.au/~/media/Estimates/Live/eet_ctte/estimates/add_1213/answers/EW0874_13.ashx (accessed 2 September 2015).

SSCEEWR (2012), "Questions on Notice, Budget Estimates 2011-2012: DEEWR Question No. EW0322_12: Suspended Jobseekers That Are Exempted", Senate Standing Committee on Education Employment and Workplace Relations, Canberra, www.aph.gov.au/~/media/Estimates/Live/eet_ctte/estimates/bud_1112/answers/EW0322_12.ashx (accessed 2 September 2015).

The Royal Australasian College of Physicians (2010), *Realising the Health Benefits of Work: A Position Statement*, The Australasian Faculty of Occupational and Environmental Medicine, http://igps.victoria.ac.nz/WelfareWorkingGroup/Downloads/Working%20papers/Realising-the-health-benefits-of-work-May2010.pdf (accessed 2 September 2015).

ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT

The OECD is a unique forum where governments work together to address the economic, social and environmental challenges of globalisation. The OECD is also at the forefront of efforts to understand and to help governments respond to new developments and concerns, such as corporate governance, the information economy and the challenges of an ageing population. The Organisation provides a setting where governments can compare policy experiences, seek answers to common problems, identify good practice and work to co-ordinate domestic and international policies.

The OECD member countries are: Australia, Austria, Belgium, Canada, Chile, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Luxembourg, Mexico, the Netherlands, New Zealand, Norway, Poland, Portugal, the Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey, the United Kingdom and the United States. The European Union takes part in the work of the OECD.

OECD Publishing disseminates widely the results of the Organisation's statistics gathering and research on economic, social and environmental issues, as well as the conventions, guidelines and standards agreed by its members.

OECD PUBLISHING, 2, rue André-Pascal, 75775 PARIS CEDEX 16
(81 2015 26 1 P) ISBN 978-92-64-24658-4 – 2015

Mental Health and Work

AUSTRALIA

Contents

Further reading

Sick on the Job? Myths and Realities about Mental Health and Work (2012)

Mental Health and Work: Belgium (2013)

Mental Health and Work: Denmark (2013)

Mental Health and Work: Norway (2013)

Mental Health and Work: Sweden (2013)

Mental Health and Work: Switzerland (2014)

Mental Health and Work: United Kingdom (2014)

Mental Health and Work: Netherlands (2014)

Mental Health and Work: Austria (2015)

Mental Health and Work: Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work (2015)

www.oecd.org/employment/mental-health-and-work.htm

OECD publishing
www.oecd.org/publishing

ISBN 978-92-64-24658-4
81 2015 26 1 P

9 789264 246584