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Ms. Amanda Rishworth MP
Chair of Standing Committee on Education and Employment
House of Representatives Standing Committee on Education and Employment
PO Box 6021
Parliament House
Canberra ACT 2600

Dear Ms. Rishworth,

Please find attached our submission to the Inquiry into Mental Health and Workforce Participation.

Our submission suggests a possible way to sort and rank evidence for social policymakers, such that the vast literature can be classified with greater ease and efficiency. We also propose a few ways to increase the labour force participation of people with mental ill health.

Yours sincerely,

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Federal Member for Fraser

## Improving Workforce Participation of People with Mental Ill Health

People with mental ill health obtain significant social benefits from employment, such as a greater sense of personal achievement and confidence. The economic case for improving their workforce participation is just as strong. Australia's unemployment rate was 5 per cent in February 2011, which is identified by the Treasury as "full employment". This refers to the unemployment rate below which high demand causes inflation to rise. In such an economy, the most effective way to improve Australia's employment rate is to target groups in society who are outside the labour force. One such group is people with mental illness.

In the ABS's 2003 *Survey of Disability, Ageing and Carers*, the workforce participation rate of people with mental illness was just 28 per cent, as compared to 63 per cent for the general population[1]. Australia has also performed poorly relative to most OECD countries in terms of workforce participation by people with disability, including those with mental illness.[2] The lack of more recent estimates could be addressed to better inform policy and to clearly identify characteristics with the greatest impact on labour force participation.

### Using an Evidence Hierarchy

The Fourth National Mental Health Plan emphasises a commitment to evidence-based policymaking. Given the vast literature about mental health, it is essential that policymakers have a framework to efficiently sift through evidence. In medicine, an 'evidence hierarchy' ranks evidence according to a set of methodological criteria. Here we describe a similar approach suggested by one of the authors for social policymaking in Australia.[3] The approach follows the UK Government's evidence hierarchy, and similarly prioritises systematic reviews and randomised controlled trials.

**Box 1: A possible evidence hierarchy for Australian policymakers**

1. Systematic reviews (meta-analyses) of multiple randomised trials
2. High quality randomised trials
3. Systematic reviews of natural experiments and before-after studies
4. Natural experiments (quasi-experiments) using techniques such as differences-in-differences, regression discontinuity, matching or multiple regression
5. Before-after studies
6. Expert opinion and theoretical conjecture

Additional criteria: Studies should be preferred if they are published in high-quality journals, if they use Australian data, if they are published more recently, and if they are more similar to the policy under consideration.

The evidence hierarchy approach gives systematic reviews precedence over single studies. Systematic reviews allow researchers to quickly gain a sense of the preponderance of evidence, without having to

[1] Australian Bureau of Statistics (2004), Table 17, Disability, Ageing and Carers: Disability and Long Term Health Conditions, Australia 2003, Cat. no. 4430.0.55.002, ABS, Canberra.
[2] Organisation for Economic Co-operation and Development (2003), Transforming Disability into Ability: Policies to promote work and income security for disabled people, OECD, Paris.
[3] Andrew Leigh (2009), What Evidence should Social Policymakers Use?, Australian Treasury Economic Roundup, Vol. 1, pp. 27-43, 2009.

read each of the studies. Systematic reviews are particularly valuable if the literature is comprised of many well-designed studies with small sample sizes.

The approach also ranks methodologies by the credibility of the 'counterfactual' – what would have been observed in the absence of the intervention. Randomised controlled trials perform the best. With a sufficiently large sample, assigning individuals to the treatment or control group by randomisation ensures that the two groups are evenly matched. With randomisation, the two groups should have similar observable characteristics (such as education or income), and similar unobservable characteristics (such as motivation or self-control). Randomised controlled trials are therefore known as the 'gold standard' in policy research. This is a major advantage over techniques used by natural experiments. For example, multiple regression approaches are unable to hold constant unobservable traits. Yet randomised policy trials remain relatively rare, with 24 medical randomised trials being conducted for each randomised policy trial.[4] This may reflect a lack of familiarity with the technique, or a perception of randomised policy trials as being unethical, because those in the control group do not receive a potentially effective intervention.

Numerous randomised controlled trials (RCTs) have been conducted to evaluate the effectiveness of supported employment for people with mental illness. Many of these studies focus on evaluating the impact of the Individual Placement and Support (IPS) model. Overall, results demonstrate that IPS is more effective in enabling people with mental illness to gain competitive employment. On average, IPS gives rise to a competitive employment rate of 60 per cent compared with 23 per cent for the various control groups.[5] There is also strong support for its generalisability across different countries and welfare contexts. We highlight a few of these RCTs below.

United States:

- In one of the most extensive studies, Cook et al. assess the effectiveness of programs that integrated mental health and vocational rehabilitation services to achieve competitive employment[6]. 1273 outpatients with severe mental disorders from 7 states were randomly assigned to a control group (without integrated services) or a treatment group (with integrated services). The results indicated that integrated services increased the likelihood of obtaining competitive employment and earning higher wages.
- Drake et al. compare the effectiveness of IPS and the standard Enhanced Vocational Rehabilitation (EVR) – where stepwise vocational services are delivered by rehabilitation agencies[7]. 152 subjects were randomly assigned to IPS or EVR. Results indicated that IPS participants were much more likely to become competitively employed and to work at least 20 hours per week.
- Lehman et al. assess the effectiveness of IPS relative to the usual psychosocial rehabilitation services for improving employment[8]. 219 outpatients with severe mental illnesses were randomly assigned to either program. The study finds that IPS participants had a higher chance of working for some amount of time during the two-year study period and were more likely to obtain competitive employment. However, Lehman et al. also conclude that while IPS participants had a slightly higher job retention rate at the end of the study period than participants from the control group, their job retention rate remained low.

[4] The Economist (2002), Try it and see, Economist, 2 March, 73-74.

[5] Jyden Lawlor and Daniel Perkins (2009), Integrated support to overcome severe employment barriers, Brotherhood of St. Laurence and The Centre for Public Policy, Social Policy Working Paper No. 9.

[6] Cook (2007), Effects of co-occurring disorders on employment outcomes in a multisite randomized study of supported employment for people with severe mental illness, Journal of Rehabilitation Research and Development, Vol.44, no. 6.

[7] Drake et al. (1999), A randomized clinical trial of supported employment for inner-city patients with severe mental disorders, Archive of General Psychiatry, vol.56, no. 7, pp.627–33.

[8] Lehman et al. (2002), Improving employment outcomes for persons with severe mental illnesses, Archive of General Psychiatry, vol.59, no. 2.

Europe:

- Burns et al. test the effectiveness of IPS relative to vocational services.[9] 312 patients with severe mental illness were randomly assigned in six European centres to receive IPS – mental health and vocational services – or vocational services. Their employment outcomes were followed up for 18 months. The study finds that despite the widely differing labour market and welfare contexts, IPS participants performed better in all employment outcomes. They were more likely to enter competitive employment, less likely to drop out of the vocational services program and less likely to be readmitted to hospital.

Australia:

- Killackey et al. evaluate the effectiveness of IPS for people with first episode psychosis at the ORYGEN youth mental health service in Victoria.[10] 41 people were randomly allocated to a control group without IPS or a treatment group with IPS. Despite the relatively small sample size, the study found statistically significant differences between the treatment and control groups. Results showed that IPS participants were better able to find work, worked for a longer period of time and earned higher wages.
- Christensen et al. assess the effectiveness of two internet interventions for people with symptoms of depression. 525 participants from Canberra were randomly allocated to a website providing information about depression, a website offering cognitive behaviour therapy for the prevention of depression, and an attention placebo (control group) where an interviewer conversed regularly with participants. The study finds that the two internet interventions reduced symptoms of depression relative to the control group. Participants accessing the internet interventions showed increased knowledge of treatments for depression and reduced dysfunctional thinking.

**Recommendations**

1. *Conduct more randomised controlled trials on supported employment programs*

Randomised controlled trials have informed mental health policymaking to a large extent. Their results have prompted commitment to integrated and supported employment programs. In Australia, the IPS approach is relatively new and few trials have been conducted. The committee should consider whether more randomised trials would be a useful way to improve the evidence base. If so, more trials could be conducted to better inform policy.

2. *Strengthen peer support networks*

People with mental ill health may choose not to join the workforce due to a lack of motivation or knowledge of available employment services. A lack of motivation often stems from low confidence, poor social skills or not having recent work experience.[11] One way of dealing with this is to strengthen the existing peer support networks and to increase their accessibility. A successful example is the Project Return Peer Support Network, an extensive program supported by Mental Health America that is run by and for people with mental illness. Their social activities and community involvement projects have helped members to build up their self-confidence and social skills. The program also employs people with mental illness, allowing them to gain work experience. Further, peer support meetings often involve discussions about policy-relevant topics. They can therefore be a useful, on-going source of opinions and suggestions that could better inform policy and allow quicker response

[9] Burns et al. (2007), The effectiveness of supported employment for people with severe mental illness: a randomised controlled trial', The Lancet, vol.370, no. 9593, pp.1146–52.

[10] Killackey et al. (2007), Results of the first Australian randomised controlled trial of individual placement and support in first episode psychosis, ORYGEN Research Centre, University of Melbourne.

[11] Alam et al. (2010), Working with barriers, Break Thru People Solutions, New South Wales.

by the government to issues on the ground. Ideally, there should be regular support group meetings for both people with mental illness, as well as their carers.

3. *Speed up the integration of employment and mental health services*

The integration of governmental and non-governmental employment services with public mental health services could usefully be accelerated. Randomised controlled trials in the United States have shown that having both facilities at the same location can significantly improve the employment outcomes of people with mental illness.[12] Those currently looking for jobs can enjoy greater access to available employment services and advice from health professionals on hand can improve job-matching. The integration of employment and mental health services can also reach out to those who are not looking for work. By raising clients' awareness of employment opportunities and having health professionals affirm their ability to work, more of them will be encouraged to join the workforce.

4. *Addressing work disincentives due to welfare benefit withdrawals*

The availability of welfare benefits and the fear of losing them provide work disincentives. In recent years, several changes have been made to minimise these disincentives. For example, in 2008 the requirement that Disability Support Pension (DSP) recipients undergo an eligibility review to access employment services was removed, eradicating fears of benefit withdrawal. Such changes have been met with positive results.[13] Further studies could be undertaken to quantify the financial disincentives due to benefit withdrawals, when people with mental illness choose to work and as they increase their working hours. These studies should include a wide range of relevant benefits and possibly other costs of working such as transport costs.

In addition, help with understanding benefits could be provided as part of employment support programs. Benefit planning services have improved the employment outcomes of people with psychiatric disorders in the US.[14] Through well-informed benefits counsellors, their concerns of losing benefits due to work can be addressed. Benefit counselling services can be especially important as such concerns are often based on misconceptions.[15]

5. *Focus on both younger and older people*

Mental illness affects individuals across the age spectrum, so interventions to boost employment rates should also be accessible to people of all ages. A focus on young people is important, but it should not be to the exclusion of programs that assist older people. The 50 year-old with depression is just as valuable a citizen as the 20 year-old with schizophrenia. Both should have access to programs that provide employment opportunities.

**Conclusion**

It is crucial to raise the workforce participation rates of people with mental illness, especially since their numbers have been increasing rapidly. Employers will be able to access a larger supply of labour to fill shortages, while people with mental illness can enjoy lives of dignity. A framework to rank

[12] Twarmley et al. (2003), Vocational rehabilitation in schizophrenia and other psychotic disorders: a literature review and meta-analysis of randomized controlled trials, Journal of Nervous & Mental Disease, Vol. 191 Issue 8.
[13] DEEWR (2009), National Mental Health and Disability Employment Strategy.
[14] Timothy Tremblay et al. (2006), Effects of benefits counselling services on employment outcomes for people with psychiatric disabilities, Psychiatric Services, Vol 57 No. 6.
[15] Virginia Commonwealth University and University of Massachusetts (2005), Employment supports for individuals with severe mental illness, Training and Technical Assistance for Providers.

research can speed up the policymaking process. A greater emphasis on conducting randomised controlled trials could also allow policy to be better informed.