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

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<th>Key policy challenges</th>
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| 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. |
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| 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. |