



Public Health Association
AUSTRALIA

Public Health Association of Australia Submission to the Productivity Commission's Inquiry into the Role of Improving Mental Health to Support Economic Participation and Enhancing Productivity and Economic Growth

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Preamble

The Public Health Association of Australia

The Public Health Association of Australia (PHAA) is recognised as the principal non-government organisation for public health in Australia working to promote the health and well-being of all Australians. It is the pre-eminent voice for the public's health in Australia.

The PHAA works to ensure that the public's health is improved through sustained and determined efforts of the Board, the National Office, the State and Territory Branches, the Special Interest Groups and members.

The efforts of the PHAA are enhanced by our vision for a healthy Australia and by engaging with like-minded stakeholders in order to build coalitions of interest that influence public opinion, the media, political parties and governments.

Health is a human right, a vital resource for everyday life, and key factor in sustainability. Health equity and inequity do not exist in isolation from the conditions that underpin people's health. The health status of all people is impacted by the social, cultural, political, commercial, environmental and economic determinants of health. Specific focus on these determinants is necessary to reduce the unfair and unjust effects of conditions of living that cause poor health and disease. These determinants underpin the strategic direction of the Association.

All members of the Association are committed to better health outcomes based on these principles.

Vision for a healthy population

A healthy region, a healthy nation, healthy people: living in an equitable society underpinned by a well-functioning ecosystem and a healthy environment, improving and promoting health for all.

Mission for the Public Health Association of Australia

As the leading national peak body for public health representation and advocacy, to drive better health outcomes through increased knowledge, better access and equity, evidence informed policy and effective population-based practice in public health.



Introduction

The PHAA welcomes the opportunity provided by the Productivity Commission's inquiry into the role of improving mental health to support economic participation and enhance productivity and economic growth.

Within the ranks of the PHAA are members who contribute to advocacy, research, policy development and the provision of programs for whole of population mental health and for people with mental health challenges. These range from initiatives for low prevalence mental health conditions (including psychoses) to more common conditions such as anxiety and depression, to whole of population initiatives (e.g. workplace wellbeing).

We seek to work constructively with the Commission throughout this inquiry.

This submission will be divided into three sections:

1. Mental wellbeing and the workplace
2. Access to employment and support within employment for people with low-prevalence mental disorders
3. Achieving the right to employment for people with low prevalence mental disorders

Key Messages

- Workplaces are well-positioned to promote mental health through the development of mentally healthy environments. Workplaces that have manageable job demands, enable work-life balance and create a psychosocially safe setting free of discrimination, bullying and harassment make economic sense as they can reduce absenteeism, presenteeism, and employee turnover.
- Individuals with low prevalence mental disorders and carers of people with these illnesses continue to have difficulty in finding and maintaining work which can be detrimental to their wellbeing. Supported employment, flexible workplace programs, and addressing discrimination and stigma are required for access to and maintenance of employment.
- Mental health problems and disorders are influenced by inequities and unevenly distributed across Australia. It is the view of our Association that these inequities should be addressed through government-led action that addresses their cause and ameliorates their impact.

1. Mental wellbeing and the workplace

1.01. The role of employment as a determinant of health

In this submission we consider the relationship between high-prevalence (e.g. anxiety and depression) and low prevalence (e.g. schizophrenia) mental health conditions and workplace environments, labour productivity, and access to employment. We also consider mental health and workplace issues for the entire population – as employment is an important determinant of health.

Access to employment and safe and supportive working conditions are strongly related to mental health. Paid employment offers positive benefits including financial security, a daily routine, reinforcing a sense of worth, and providing a space for regular social connectivity⁵. An individual's health status is impacted by the nature of their work⁶, however many of the benefits of work only apply to jobs that have a positive psychosocial environment.

Consistent evidence shows that poor quality work settings which have a detrimental psychosocial environment including high job demands, low job control, poor job security, and lack of support from supervisors and colleagues can have an adverse effect on mental health. Employment in a poor work environment has been shown to facilitate similar or higher risk of psychological stress in employees as those who are unemployed⁷.

Moreover, there is a wide employment gap between people with and without mental health problems; with those with mental health complaints experiencing unemployment rates up to four times higher than healthy Australians⁸.

1.02. Workplace issues relevant to mental wellbeing

Occupations with the highest rates of claims for mental health conditions come from the defence force, emergency services (especially fire fighters and police), transport operators, health and social support workers, and prison and security officers⁹.

Negative workplace conditions that can adversely impact the mental health of employees can include⁹

- | | |
|-------------------------------------|---|
| • too much or too little job demand | • unsafe environmental conditions |
| • insufficient support | • unfair organisational justice |
| • negative workplace relationships | • bullying and harassment (including sexual harassment) |
| • low job clarity | • remote or isolated work |
| • inadequate change management | • exposure to violent or traumatic events |

A systematic review of anxiety and depression in male dominated industries (defined as those where more than 70% of the workforce is male, e.g. agriculture, construction, mining, and utilities) has shown that the main risk factors associated with anxiety and depression in these industries were unsupportive workplace relationships, job overload, and job demands. Some studies indicated a higher risk of anxiety and depression for blue-collar workers¹⁰.

Some sectors and professions are more vulnerable than others in terms of workplace stress and mental health and wellbeing. In a national mental health and wellbeing study of police and emergency services, it was found that poor workplace practices and culture were as damaging to mental health as occupational

trauma¹¹. In addition, health professionals, especially nurses, are more likely to take days off due to stressors such as demanding workload and work overload, time pressures, and low workplace support compared to workers in other industries¹². These stressors can contribute to adverse physiological health outcomes including elevated blood pressure and escalated stress hormone production¹².

Three quarters of Australian workers believe workplaces should provide support to someone who is experiencing depression or anxiety¹³. In workplaces that are not supportive of mental health, employees are unlikely to disclose to their workplace or seek support from HR or management if they are experiencing a mental health condition, or offer support to a colleague with a mental health condition¹³. Flexible leaders who are willing to accommodate and adapt to the unique needs of colleagues, and who support early intervention and returning to work are important for engaging and caring for employees with a mental health condition¹⁴ or episode. Supportive working environments and strong leadership are therefore critical for promoting mental health as well as help-seeking behaviours when a person experiences a mental health problem.

1.03. Working conditions

Short term contracts, job insecurity and involuntary part time employment are becoming increasingly common¹⁵; with about one in every five Australians working casually¹⁶. Contract work arrangements are associated with low incomes, fewer entitlements, and poor working conditions such as poorer supervision, inadequate training, exposure to higher risk tasks, and workplace disorganisation¹⁵. Furthermore, temporary employment, perceived job insecurity, major organisational restructuring, and downsizing are positively linked with mental health problems and psychological distress¹⁵.

Casual work is often associated with job dissatisfaction, job and financial insecurity, and low social support which can significantly increase levels of poor mental health¹⁷. Casual work is commonly observed amongst women, immigrants, and young Australians; groups with historically less power to negotiate labour rights and conditions¹⁷.

Case Study – FIFO workers

Fly-in, fly-out (FIFO) employment requires workers to commute long distances to remote worksites and live in provided accommodation for 1-4 weeks whilst on shift. This work format is commonly associated with the energy/natural resources industry and offers benefits to employees including being part of a challenging work environment, having unique opportunities to meet other people, and earning a high income². Loneliness, fatigue and problems with work-life balance (i.e. impact on relationships) are also commonly associated with the FIFO work arrangements²; with workers particularly vulnerable to increased levels of psychological distress, poor sleep, isolation, lack of autonomy, and being exposed to or witnessing bullying⁴. Coupled with riskier alcohol and drug use and workers generally being a part of an at-risk demographic profile (gender, age, education, job role); suicide risk is greater in this workforce compared to other industries⁴.

1.04. Workplace restructuring

Workplace restructuring has been linked to poor mental health. *Good Practice in Socially Responsible Restructuring*¹⁸ discusses ways in which employers can positively support workers during restructuring, which in turn is associated with increased productivity, reduced absenteeism, higher worker morale and brand loyalty. This resource reinforces the importance of transparency and ongoing support (regarding the retrenchment process), career and training assistance, skills recognition and support for finding a new job¹⁸.

1.05. Workplace bullying and discrimination

Workplace bullying can adversely affect the wellbeing, outcomes and productivity to each and all of those targeted by bullying, witnesses to bullying, and those accused of bullying. Targets of workplace bullying are at risk of having poorer mental and physical health, lower job satisfaction and greater career disruptions, and feel less secure about their jobs¹⁹. Research has also shown that both those suffering from bullying and those witnessing bullying can suffer from depression²⁰.

A survey of 3000 Australians found that certain population groups (e.g. Aboriginal and Torres Strait Islander workers, workers with a disability) are up to twice as likely to experience harassment and discrimination compared to mainstream or other groups (e.g. non-Aboriginal and Torres Strait Islander workers, workers without a disability)²¹. In the same study, it was found that young people (under 30 years), LGBTI workers, and carers also experience high rates of discrimination in the workplace.

In 2018, the former chief executive of France Telecom (now named Orange) and six other managers stood trial after a string of suicides, suicide attempts, and mental illness were linked to bullying and poor support for restructuring within the organisation²². Awareness of such examples provides reinforcement for the obligations of employers to keep their workers safe.

1.06. Young people and employment

Young people entering the workforce are more likely to experience work stress and psychological stressors such as bullying and harassment, low job control, and conflict with supervisors and co-workers. Young people also have an increased vulnerability to mental health problems and alcohol and drug related harm during this transition, especially for those under 25 years²³. Temporary employment, job insecurity, and poor employment protection affect quality of life and life satisfaction in young people and increase the probability of occupational injury risks, mental health disorders, and physical health problems²⁴. Young unemployed adults also show poorer psychological health, poorer quality of life, and higher prevalence of risk behaviours such as smoking, excessive alcohol consumption and less healthy lifestyles²⁴.

1.07. The impact of involvement with the justice system and homelessness on the employment and mental health of young people

People exiting the juvenile justice system can face issues of cyclical homelessness and unemployment. These issues are closely linked, with unemployment a common precedent to homelessness and vice versa²⁵. Young people leaving the juvenile justice system have disproportionate rates of previous child protection involvement, suspension or expulsion from school, mental health and substance use problems, and histories of suicidal ideation and self-harm compared to their non-offending peers²⁵. A 2008 meta-analysis of mental health issues among youth in detention found rates of psychosis 10 times those found in the general community²⁶.

Involvement with the justice system also reduces the young person's ability to attain educational credentials that promote positive employment opportunities²⁷. Stigma of an arrest can also lead to reduced employment opportunities. These complex issues create a challenging role for intervention efforts promoting positive employment outcomes. Cost benefit and outcome analyses of employment and mental health programs and contemporary evidence of the prevalence of mental health disorders within the juvenile justice system are required to develop more effective employment and mental health outcomes for justice-involved young people.

1.08. LGBTI people: a snapshot of mental health and the workplace

It is estimated that about 1 in 10 (11%) of Australians identify as Lesbian, Gay, Bisexual, Transgender, or Intersex²⁸. Within the workplace, discrimination towards sex, sexual orientation, gender identity or intersex status can and still does occur²⁹ despite amendments in 2013 to the Sex Discrimination Act 1984 which states that it is unlawful to do so³⁰. The Anti-Discrimination Act 1977, (within the 'Discrimination against applicants and employees' section), also offers legal protection to this group in the workplace³⁰.

However, LGBTI people continue to experience significant levels of mental health problems and mental health disorders. Some of this is linked to discrimination, harassment and bullying which may occur in an educational setting or workplace environment.

LGBTI people have been shown to have high levels of anxiety and depression, and have the highest rates of suicidality of any population group in Australia²⁸. Young LGBTI people aged 16-27 are five times more likely to attempt suicide than the general population. Furthermore, young LGBTI people are nearly twice as likely to engage in self-injury and nearly three times more likely to be diagnosed with depression in their lifetime than the general population³¹. Stigma and discrimination in the form of stereotyping, labelling and status loss³² are likely contributors to these adverse mental health outcomes. This kind of stigma is related to the experience of LGBTI people within workplaces; with evidence showing more than one in five young LGBTI people expend energy hiding their sexuality to fit in work³³. Reasons for this include not wanting to be labelled, not feeling comfortable enough to be out at work, and being uncertain of the repercussions³³.

1.09. Economic impacts of mental health: absenteeism and presenteeism

Absenteeism contributes to profit and performance losses to organisations through decreased productivity, missed deadlines, increased costs for replacement staff and overtime pay for the replaced workers, and lowered morale among staff³⁴. Poor mental health is estimated to be associated with 50-60% of all workplace absenteeism¹⁰. A 2010 study found that psychological distress increased absenteeism by 1.7% and decreased employee performance at work by 6.1%⁸.

Strong predictors of work absenteeism associated with mental illness include history of sickness absence, self-reported exhaustion, the individual's reaction to symptoms and the communication with the supervisor³⁵. Moreover, sexual harassment at work can lead to adverse psychological outcomes such as anxiety, depression, and post-traumatic stress disorder, which in turn are strongly linked to absenteeism, lower job satisfaction and productivity, and employment withdrawal³⁶.

The estimated impact of mild depression in Australia is a decrease of 3.9% in labour productivity, rising to 9.2% for severe depression. The costs associated with depression in the workplace are largely attributable to absence from work (absenteeism), presenteeism (present at work but not optimally productive), and job turnover, as opposed to health care costs^{37, 38}. Depression is also associated with costs due to work impairment and disability³⁹.

After an absence relating to mental health, returning to work can be difficult for multiple reasons including both factors related to the mental health issue and a lack of social support from peers or managers⁴⁰.

Presenteeism (attending work whilst ill) can influence the performance of workers who have a mental health issue. Changes to the work environment which can contribute to issues such as perceived job insecurity can lead to employees being present rather than taking an absent day³⁸. Costs arising from presenteeism are estimated to be four times higher than that of absenteeism⁴¹.

USA and European estimates suggest economic impacts of between 2.5-4% of GDP could result from mental health problems, mostly due to reduced workplace productivity¹⁶. In 2015-16, the cost of workplace mental ill-health to the Australian economy was \$12.8 billion, consisting of \$348 million in direct costs from mental health related workplace injuries; \$2.6 billion in absenteeism from reduced days of work for employees with mental health issues; and \$9.9 billion in presenteeism, accounting for lost productivity for employees with mental health issues⁴².

In 2014, PricewaterhouseCoopers estimated that the economic return in investing in a mentally healthy workplace (prevention, early intervention, rehabilitation and return to work strategies) was \$2.30 for the organisation for every dollar spent. These benefits are attributed to a reduction in presenteeism, absenteeism, and compensation claims⁴³.

1.10. Impact of suicide

There are many impacts of suicide including psycho-social impacts on individuals, families, communities and workplaces. There are also economic costs of suicide and non-fatal suicidal behaviour: costs are estimated to be over \$6.73 billion, with the majority (97%) of the burden of cost borne largely by the government¹. A 2016 analysis found that a male construction industry worker dying from suicide cost the economy \$2.14million, with each worker losing an average of 27.3 years of potential productive employment and 42 years of potential life lost. The total economic cost of suicide and suicidal behaviour to the NSW construction industry alone was estimated at \$527 million⁴⁴. If employers were more aware of the economic consequences of the impact of mental health problems and disorders on their employees, the workplace may provide a more effective environment for mental health promotion and suicide prevention¹.

Higher suicide rates are generally observed in workplaces with physical and psychological hazards and poor working conditions⁴⁵. These might include having obtainable access to lethal means (e.g. guns, pesticides), exposure to harmful chemicals, high workplace stress, low wages, and inconsistent work schedules (e.g. shift work)⁴⁵.

1.11. Responses: Improving conditions of work: current legislation and initiatives

Under the *Work Health and Safety Act 2011*, workplaces must prevent harm to the physical and psychological health and safety of workers. Officers, people who make or participate in making decisions in a business or undertaking, have a duty to be proactive and continuously ensure that the business or undertaking complies with relevant duties and obligations⁴⁶. Common psychological hazards in the workplace may include negative organisational cultures, poor leadership, lack of opportunities for professional development, and low psychological support⁴⁷.

Boland⁴⁸ highlights that there is a lack of specific regulations regarding psychological health in the national *Work Health and Safety Act 2011* and that psychological health is often neglected in the Act's regulations and codes. One of the recommendations from this report was to amend the current WHS Regulations to address the identification of psychological risks within the workplace and the appropriate control measures to manage these risks⁴⁸. The Australian Mentally Healthy Workplace Alliance has prioritised work on a National Workplace Initiative to address workplace mental health, including contribution from stakeholders in the UK and Canada, where national initiatives are already in place⁴⁹.

1.12. Responses: Creating mentally healthy workplaces and mental health promotion initiatives

Healthy workplaces provide and encourage professional development, identify and remove mental health hazards, and view diversity as an organisational advantage. Staff turnover and sick/stress leave is low, staff loyalty is high, and workers are productive members of the team. Furthermore, senior staff and managers are committed to creating healthy work environments and value consultation from workers on how these processes are implemented⁵⁰. Recognising and promoting mental health is a critical part of providing a safe, supportive, and healthy workplace⁵⁰, however, many mental health strategies in work environments are often reactive and implemented without an effective evidence base.

Holistic workplace mental health frameworks have been developed to address this issue, such as the integrated approach by LaMontague et al.⁵¹ which involves preventing harm, promoting the positive (e.g. ensuring meaningful work, good leadership, focussing on strengths), and responding to illness. Another framework currently used by the Australian Mental Health Commission includes five broad workplace strategies including designing work to minimise harm, promoting and facilitating early help seeking, and supporting recovery and return to work⁵². This particular framework argues that optimal workplace mental health is best facilitated through a multi-pronged approach of preventative and reactive strategies that are targeted at the individual, team, and organisation level. Each of the strategies within the framework are evidence-based and display promising potential for improving mental wellbeing in the workplace. However, there are gaps in the currently available research, and there needs to be more research on the contextual factors that may impact on the framework – including compensation policies and access to services⁵².

Mental Health Australia estimated in 2018 that strategies such as increasing employee job control and formal cognitive behavioural therapy training would produce a collective \$4.6 billion in workplace mental health savings through improving wellbeing, and reducing stress and absenteeism⁴².

Battams et al.¹⁰ highlight the need for organisational over individual level strategies for workplace mental health promotion and prevention. Proactive measures suggested to achieve a healthy and safe workplace may include: allowing flexible working hours; identifying effort/reward balance; offering mentoring and counselling services; ensuring sustainable mental health education and training is available; and enforcing safe and healthy conditions (regular breaks, overtime limits, conflict resolution procedures)^{10, 50}.

Additionally, current evidence of interventions such as manager training in workplace mental health, anti-stigma programs, mindfulness and mental health first aid have shown promising results for improving mental health literacy, building resilience, and developing supportive and proactive mental health behaviours⁵³.

1.13. Responses: Establishing programs to prevent suicide in the workplace

The World Health Organization's 2006 report outlining suicide prevention initiatives in the workplace includes strategies that can be implemented in work environments such as manager training on how to identify and respond to suicidal workers and how employees can support their colleagues⁵⁴. Evans-Lacko & Knapp⁵⁵ also identify that cultural contexts (including within workplaces) that are open and accepting of mental illness are associated with higher rates of help seeking, antidepressant use and empowerment, and lower rates of self-stigma and suicide.

Flexibility within and the support of workplaces (including respect for privacy and confidentiality) is crucial for employees who may have suicidal ideation/suicidal behaviours and associated hospitalisation or attendance at health care settings.

Most suicide prevention activities aim to reduce risk and make sure help is available (secondary and tertiary prevention), which is critically important, but fail to address factors at the primary level, including modifiable risk factors for suicide in workplace environments. These risk factors include low control over work, monotony of work, and high psychological demands among others that have been previously mentioned such as low social support and high job insecurity. Addressing these factors in the workplace is seen as best practice in mental health and job stress interventions⁵⁶.

Case Study – MATES in Construction (MIC) is one example of a multifaceted workplace suicide prevention strategy and was developed to address suicide and mental illness in this industry¹. A 2017 analysis found that if a suicide strategy such as MIC was universally implemented, there might be on average 8.2 fewer suicides, 21.0 fewer self-harm attempts ending in full incapacity, and 102.3 fewer self-harm attempts ending in a short absence from work (5 days or fewer). For every dollar invested in a workplace program like MIC, the benefits would be in excess of \$1.50, representing a positive economic investment¹. There are many other examples of suicide prevention training programs that have been used within workplaces. Presently there is a lack of a good evidence base regarding the effectiveness of such programs and this could be one area for future funding support.

Summary of Section 1. Mental wellbeing in the workplace

- Working can have a positive impact on a person's mental health if they are working in a supportive and safe environment.
- Emergency services, defence, health, FIFO and agriculture workers are some of the occupations at higher risk of being exposed to workplace psychological hazards and conditions.
- Psychosocial hazards and conditions at work such as insufficient support, job insecurity, negative workplace cultures and high job demands can be detrimental to a person's mental health and may contribute to reduced productivity and increase absenteeism and presenteeism.
- Workplace restructuring needs to be executed in a socially responsible manner to prevent mental ill health.
- Certain groups such as LGBTI people, Aboriginal and Torres Strait Islanders and young people have particular barriers and challenges in the workforce, including bullying, harassment, and stigmatisation, which can have a negative impact on their mental health.
- Absenteeism and presenteeism are costly to individuals, employers, workplaces and the economy as a whole.
- Workplaces are well positioned to create mentally healthy work environments and if implemented will see benefits including increased staff loyalty, reduced absenteeism and presenteeism, and increased productivity. Workplace flexibility is key for those who have a mental health episode or condition.
- In Australia, suicide is a major cause of death among people of working age¹, particularly middle-aged males³. It is pertinent to continue developing, implementing, and evaluating sustainable workplace mental health promotion and suicide prevention initiatives to reduce the number of suicides, suicide attempts, and reduce workplace related mental illness and associated stigma, as well as to promote help seeking behaviours and support workers (and family members) who have had a mental health episode or suicidal ideation/attempt.

2. Access to employment and support within employment for people with low-prevalence mental disorders

2.01. Access to employment

Access to employment is a major issue for people with low prevalence mental health disorders. Many people with chronic and severe mental disorders have high levels of psychiatric disability, requiring ongoing management of their conditions, support for employment and workplace flexibility.

Australians with low prevalence mental disorders such as schizophrenia and bipolar disorders have much lower rates of being employed compared to the general community (21.5% vs. 72.4%) and higher rates of being homeless (5.2% vs. 0.5%)⁵⁷. A large Norwegian study showed that only 5% of those with schizophrenia were in employment⁵⁸ whilst in the UK only 8% of people with schizophrenia are employed⁵⁹ – whilst figures for Australia are not available. The Organisation for Economic Coordination and Development (OECD) estimates that unemployment is 3-6 times higher in people with a severe mental disorder than for people with no mental disorder⁶⁰.

People with severe mental disorders have longer periods of unemployment than those without a mental illness, increasing their risk of becoming discouraged and withdrawing from the labour market⁶⁰. Similar to the general population of unemployed people, people with schizophrenia can experience unemployment as a source of anxiety and despondency associated with poverty, a lack of meaningful societal roles, a reduction in social interaction and contacts, and a lack of routine and structure⁶¹.

More people with severe mental disorder (than those without) have a lifetime working history of less than ten years and fewer have a record of 40 years or more, compared with people within the general population. Workers with a mental disorder generally hold less stable and less well-paid jobs than other workers; annual income is lower, with far more workers with a mental disorder earning less than the median wage⁶⁰.

This information is incongruous with the consistent evidence that people with a severe mental illness want to work⁶². For people with schizophrenia and other low prevalence mental disorders, employment is synonymous with a “normal life” and provides a routine that assists with recovery, improves self-esteem, increases autonomy and independence, and positions them in a social environment in which diminishes the stigmatised identity of having a mental illness⁶³.

However, multiple societal barriers inhibit access to employment for this group, including community expectations and inflexibility within workplaces. There are systemic issues such as isolation and insufficient support from employment and mental health services⁶⁴, which may be attributable to the intermittent needs of an episodic mental illness. The largest barrier to employment for people with severe mental illness is their limited access to a supportive and non-discriminatory workplace⁶⁵.

Australian data of the employment rate of people with schizophrenia is not readily available and more detailed information on the employment status of this group is required, along with comparisons on how Australia fares in terms of other OECD countries. Data from the National Mental Health Survey 2007 is becoming increasingly invalid and commissioning a new survey should be considered.

2.02. The role of stigma in workplaces and in the community

People living with a severe mental illness must face false beliefs, stereotypes, and prejudice that result from misconceptions about mental health conditions⁵⁷. Misconceptions commonly include that they are dangerous, violent or behave unpredictably; that they are incompetent and cannot look after themselves; and that their illness is a life sentence with little chance of recovery. People with severe mental illnesses report being treated unfairly by friends and family, being discriminated against in finding or keeping a job, and feeling disrespected by mental health staff⁵⁷.

Stigmatisation can also hinder people from seeking help for mental health problems or even lead to discontinuation of treatment, sometimes leading to adverse outcomes⁶⁶. Furthermore, stigmatisation and discrimination can inhibit people with mental health conditions to take up employment, stay employed or be promoted. Higher levels of internalised stigma (adopting the public's stigmatising opinions into their own thoughts) are substantially related to more severe psychiatric symptoms, poorer treatment adherence, and lower utilisation of mental health services. Poorer treatment adherence is related to poorer treatment outcomes, more rehospitalisation and increased health costs⁶⁷. High levels of internalised stigma are significantly correlated with hopelessness, poorer self-esteem and quality of life, reduced empowerment, and reduced self-efficacy; it also significantly predicts poor social functioning over time⁶⁷.

2.03. Supported employment

More opportunities for supported employment are necessary for people with low prevalence mental disorders. Supported employment (SE) is evidence-based and is grounded on rights principles, which include having a zero-exclusion policy so that anyone with an illness can participate in employment; integrating vocational rehabilitation and mental health services; and having conventional paid employment as the goal (i.e. part or full time with minimum wage)⁶⁰.

Supported employment has been shown to have positive vocational and non-vocational outcomes. It increases the rate of employment, with around half of clients using these services getting paid employed in a 12 to 18-month period, as compared to 15-30% for other vocational programmes⁶⁰. There is some evidence that SE also improves self-esteem, reduces psychiatric symptoms, improves cognitive performance and reduces re-hospitalisations⁶⁰.

The Individual Placement and Support (IPS) model is a form of supported employment which involves a multidisciplinary mental health and employment team supporting a client to find a job that matches their interests and skills and which allows for individualised professional development⁶³. The supported employment (particularly IPS) model emphasises rapidly placing an individual into competitive employment whilst giving them support to maintain this employment. A 2016 systematic review and meta-analysis identified that individuals with a low prevalence disorder who received IPS were more than twice as likely to gain competitive employment as those undergoing traditional vocational rehabilitation e.g. sheltered workshops⁶⁸. Barriers to widespread implementation of IPS include attitudinal barriers relating to beliefs of both clinicians and employers; contextual factors including the structure of the labour market and welfare systems; and organisational factors within mental health services⁶⁸.

2.04. Supporting people within workplaces

Social relationships, personal traits, and behaviours of supervisors and co-workers need to support people with mental disorders. Providing feedback, communicating openly, and being fair and encouraging are critical for employment success of people with mental disorders⁶⁵. Workplace supports such as training and

supported learning, positive relationships with colleagues, an accepting workplace culture, and effective staff management, as well as flexibility and adjustments to work roles, schedules and tasks are crucial for job retention⁶⁵.

Increased job satisfaction, positive management (offering support, giving adequate feedback, recognising the work effort and talking to the employee), family and work balance, and working shifts has been found to reduce absenteeism in people with a mental disorder⁶⁰.

2.05. Flexible working conditions and workplace accommodations

Workplace accommodations are individualised solutions that enable people with mental health disorders and disabilities to attain and maintain employment. The purpose is to create an equitable working environment where the person with a mental health condition, disability or impairment can effectively perform their work tasks and can simultaneously enjoy the benefits and privileges of employment⁶⁵. The organisation's willingness to accommodate for the individual's needs, particularly their need for flexibility of working times and duties (or in the event of a hospitalisation), is important for job satisfaction and their ability to cope with their illness whilst maintaining employment⁶⁵.

Flexible working arrangements are a relatively contemporary practice in modern workplaces and have not been extensively studied. Preliminary studies on interventions such as self-scheduling of shifts have shown positive results for improving worker mental health and wellbeing. However, interventions that are motivated or dictated by organisational interests, such as fixed term contracts and involuntary part time employment have shown to trigger negative health effects⁶⁹.

Furthermore, challenges arising from returning to work after an adverse mental health incident or injury also require addressing. Significant periods away from work due to an illness or injury can make a person feel increasingly isolated, incur financial stress, increase the chance of long term unemployment, and decrease self-esteem and quality of life⁷⁰. Frameworks with tools for workplaces to adequately support returning to work and providing flexible conditions, such as Comcare's guide to "Working for Recovery; Suitable employment for return to work following psychological injury"⁷⁰ are critical for enabling people with a mental health condition to safely and securely go back to work.

2.06. Informal carers and their employment

Informal carers save the Australian community more than \$60 billion per year by providing care that would otherwise have to be funded through health, mental health, ageing, and disability services⁷¹. As a cohort, carers have lower labour force participation, increased unemployment and reduced earnings compared to non-carers⁷².

Caring roles challenge a person's ability to sustain their pre-care employment and sometimes prevents them from working⁷³. Compared to non carers, carers experience significantly more difficulty in finding work or in remaining in education and training⁷². Carers are more likely to work part time than full time and there is an inverse relationship between hours of care provided and hours spent working⁷³. Carers will often be forced to surrender work hours to provide care and may frequently need to change work hours or take leave at short notice in response to caring duties (which again may affect employment) – this may be affected by the provision and accessibility of mental health community care or hospital conditions (e.g. wait times at ED).

Additionally, the impact of caring for a person with a severe mental illness can significantly affect the mental health of the carer. In the UK it is estimated that approximately 40% of carers of people with psychosis experience poor psychological functioning including depression and other stress-related disorders. Carers of people with psychosis often experience a poorer quality of life and feel up to ten times more isolated than non-carers⁷⁴.

2.07. Psychosis: The cost of illness of psychosis Australia

The costs of psychosis to Australia are significant. Neil et al.⁷⁵ estimated that the costs to Australia associated with psychosis were as much as \$4.91 billion, consisting of \$2.31 billion in direct expenses through health and other sectors, and the remaining \$2.6 billion in morbidity-related productivity losses. The authors suggest that without effective and proactive prevention, treatment and support strategies, these costs will remain persistent.

Summary of Section 2: Access to employment and support within employment for people with low-prevalence mental disorders

- Unemployment rates are very high in people with low prevalence disorders, despite many with these conditions wanting to work.
- Multiple barriers, especially a lack of supported accommodation, workplace support programs, employer flexibility and stigma inhibit people with low prevalence disorders from finding and maintaining work.
- People with low prevalence disorders require flexible working conditions and can benefit from supported employment programs such as IPS.
- Informal carers of people with low prevalence disorders have substantial difficulty maintaining work and require flexibility in work environments.
- The costs of psychosis are very high and broad ranging. Effective prevention, treatment, and support is required to maximise efficiency of service delivery.

3. Achieving the right to employment for people with low prevalence mental disorders

People with a mental disorder face greater challenges in gaining and maintaining employment, owing to educational disadvantage, stigma in workplaces and the community, and the episodic nature of conditions⁶⁸. However, research has shown that most people with low prevalence mental health disorders who want to work can succeed in competitive employment⁶³. This section considers the right to employment for people with psychiatric disability, and the importance of early intervention in health services to assist in recovery and maintenance of the condition, and support in education and employment.

3.01. The context: the *UN Convention on the Rights of Persons with a Disability and the Right to Employment 2008*

The United Nations defines persons with a disability as “those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and affective participation in society on an equal basis with others.” The *UN Convention on the Rights of Persons with a Disability* (UNCRPD), to which Australia is signatory, affirms:

The right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living through work freely chosen or accepted in the labour market and a work environment that is open, inclusive and accessible to persons with disabilities⁷⁶.

The UNCRPD also:

- Prohibits discrimination on the basis of disability with regard to all matters concerning all forms of employment, including conditions of recruitment, hiring and employment, continuance of employment, career advancement and safe and healthy working conditions⁷⁶.
- Enables persons with disabilities to have effective access to general technical and vocational guidance programmes, placement services and vocational and continuing training⁷⁶.

3.02. Role of discrimination law – the *Disability Discrimination Act 1992*

“The *Disability Discrimination Act 1992* makes it unlawful to discriminate against a person, in many areas of public life including: employment, education, getting or using services, renting or buying a house or unit, and accessing public places, because of their disability”³⁰.

The DDA 1992 also states that it “is not against the law to refuse to employ a person with a disability if because of their disability they cannot perform the inherent requirements of the job.” However, the employer “must consider how the person with a disability could be provided with reasonable adjustments to help them do the job.” Adjustments should not inflict “‘unjustifiable hardship’ on the employer (e.g. too expensive, difficult, time consuming) or cause some other hardship”³⁰.

3.03. Overcoming stigma in the workplace

Workplaces are well positioned to counteract stigmatising beliefs towards people with mental health conditions through anti-stigma interventions, specifically ones with focus on increased knowledge about mental health and supportive behaviour among employees. However, many of these programs are inadequately evaluated and measured⁷⁷.

3.04. Early intervention in health services

There is a strong need for early intervention in health care and in workplaces to support people who experience mental health conditions to access and maintain employment, and to prevent the development of ongoing disability.

Treatment delay is independently linked to poor outcomes in psychosis. It is therefore critical to deliver early interventions that involve multidisciplinary teams (including professionals such as psychiatrists, psychologists, and community support workers) that aim to reduce relapse and readmission rates for patients who have suffered a first episode of psychosis, and to improve their likelihood of returning to employment, education and training⁷⁸.

Scandinavian and Danish early intervention community programs focussing on education and specialist assessments have shown to be beneficial for reducing treatment delay and improving clinical outcomes such as reduced suicide risk and relapse rates, and improving social and vocational recovery. Randomised Control Trials have also shown that it is possible to delay the onset of severe and chronic psychotic illness in young people at very high risk of early transition with either low dose antipsychotic drugs or CBT⁷⁹. Evidence from the UK suggests that such early interventions for people experiencing their first episode of psychosis are a more cost-efficient method of reducing relapse and readmission to hospital and improving overall quality of life than standard care⁷⁸.

In Australia, there are currently limited early psychosis services for young people across the country – and provision of early psychosis services (e.g. as offered through Headspace) is important for maintaining young people in education and employment. Planned support for transition across adolescent/youth and adult mental health services is also important for maintaining the wellbeing of those with a mental health disorder⁸⁰. Such transition planning could involve other sectors such as health and education – to help young people with mental health conditions negotiate various areas of their life during a crucial period.

The national stepped care approach to mental health service provision has promising potential in Australia, but is weakly regulated and places inadequate accountability on Primary Health Networks (PHNs) regarding commission of services. The approach involves stratifying the population of PHNs into different ‘needs groups’ ranging from whole of population needs for mental health promotion and prevention, through to those with severe, persistent and complex conditions (such as low prevalence disorders) and allocating resources to the required services⁸¹. The model asserts that individuals can transition between the use of higher and lower intensity services as their needs change. Typical workforce requirements for supporting people with a severe mental illness within this approach include involvement of a range of health professionals (e.g. GPs, psychiatrists), provision of psychological therapy, assistance and support from mental health nurses, and a peer workforce network to complement clinical services. Evaluation of the cost effectiveness, PHNs role in accountability/implementation, and outcomes for people with mental health conditions within this system are required.

3.05. Role of the NDIS and accountability for employment outcomes

The NDIS is national scheme that assists people with disability, including psychosocial disability. People with a disability may be eligible for NDIS support if it significantly impacts their life and is likely to produce a permanent impairment⁸².

Notwithstanding, lack of expertise in psychosocial disability in NDIA assessors, planners and service providers is causing poor and inequitable service at best and severe trauma and harm at worst for people with mental health conditions⁸³. Strong care coordination is required for people with a psychosocial disability, and this is often not available through NDIS funded services, impacting on access to the scheme for people with psychosocial disabilities.

Furthermore, inadequate funding models are resulting in a lack of sustainable, and safe service or support options for those fortunate enough to be assessed as eligible for the Scheme⁸³.

The NDIS Participant Employment Taskforce has allocated \$19.9million worth of grants for projects to boost employment for Australians with a disability. However, the contribution that the NDIS is making to enabling people with a psychiatric disability to access or maintain employment requires evaluation. Currently, NDIS outcomes are uncertain for people with psychiatric disability.

Summary of Section 3: Achieving the right to employment for people with low prevalence mental disorders

- People with low prevalence disorders are entitled to seek and maintain work without discrimination under the UNCRPD 2008 and the DDA 1992.
- Early intervention for people with low prevalence disorders is critically important for better outcomes in health and in turn employment and education.
- Workplace flexibility and programs are required for people with low prevalence disorders.
- The national stepped care approach needs to be evaluated to ensure accountability of responsibility by PHNs.
- The NDIS currently does not have effective strategies to assist people with a psychiatric disability in accessing and maintaining work which is likely to significantly impact people with low prevalence disorders. More accountability for NDIS outcome for people with psychosocial disability is required.

Conclusions

In summary, we wish to leave the Commission with the following key messages:

- Working in a safe and supportive environment is protective for the mental health of the entire population. Poor psychosocial work environments can be detrimental to mental health for everyone.
- Absenteeism and presenteeism from mental health conditions are costly to individuals, workplaces, and the economy.
- People with mental health conditions and illnesses have a right to work, and presently this right is not being fulfilled for people with low prevalence disorders.
- Suicide prevention and mental health promotion strategies in workplaces are critical to providing a psychosocially supportive working environment. Given rates of presenteeism and absenteeism, such programs make economic sense.

Recommendations for action include:

- Employers and organisations should be held accountable by the *Work Health and Safety Act 2011* to keep employees safe and healthy.
- Proactive mental health strategies for prevention, early intervention, rehabilitation and return to work should be evaluated effectively to provide a strong evidence base for future workplace implementation.
- People with psychosocial disability and informal carers should be supported to find and maintain employment in flexible workplaces.
- Workplaces should be encouraged to consider organisational level workplace mental health strategies (over individual level strategies) such as policies on workplace conditions (job demand/reward), flexible working conditions and carer/domestic violence policies.
- Government, industries and workplaces should consider the mental health impacts of workforce changes such as workplace restructuring, retrenchment and casualisation of the workforce, along with insecure employment. These global changes have had a detrimental impact upon mental health.
- Young people with mental health conditions should be supported to be maintained in education, as such support will have future consequences for employment trajectories.
- People with low prevalence mental disorders should be supported to access work and to maintain employment through early intervention in the mental health sector, supported employment, supportive workplace strategies (job flexibility) and NDIS support (where appropriate).
- The NDIS should be more accountable for people with psychosocial disabilities, including initiatives aimed to promote access to and maintain people in employment.

We ask the Productivity Commission to:

- Quantify the economic impact of providing mentally healthy and safe workplaces.
- Quantify the costs of people with low prevalence disorders having very low employment participation rates.
- Estimate the economic benefit of inclusive and diverse workplaces and their impact on the mental health of employees, including the mental health of certain groups such as, but not limited to LGBTI, Culturally and Linguistically Diverse, and Indigenous workers.
- Calculate the economic deficit of mental health stigma in communities and workplaces.
- Identify the economic benefit of early intervention of low prevalence disorders in terms of workforce participation.
- Estimate the costs and benefits of supported employment and related strategies through the NDIS for people with psychiatric disabilities
- Analyse the economic effectiveness of the national stepped care approach.
- Explore strategies for early intervention involving education, employment and mental health sectors – transitional planning for young people with mental health conditions could play an important role in this regard.
- Analyse the return on investment on suicide prevention workplace mental health promotion initiatives.

The PHAA appreciates the opportunity to make this submission and the opportunity to participate in this important inquiry. We re-affirm our intention to work constructively with the Commission during the further stages of this inquiry.

Please do not hesitate to contact me should you require additional information or have any queries in relation to this submission.

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