Employment White Paper - Consultation

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Employment Taskforce

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Introduction

Lived Experience Australia Ltd (LEA) is a national representative organisation for Australian mental health consumers and carers, formed in 2002 with a focus on the private sector. All members of our Board and staff have mental health lived experience as either a consumer, family carer or both.

Our core business is to advocate for systemic change to improve mental health care across the whole Australian health system. This includes advocating for empowerment of consumers in the broad range of issues that impact their mental and physical health, empowering consumers in their own care and contact with health and social services, promoting engagement and inclusion of consumers and carers within system design, planning and evaluation and most importantly, advocating for consumer choice and family and carer inclusion and wellbeing.

Our submission comes from the perspectives and experiences of people with lived experience of mental health challenges, their families, and carers. Our comments focus on the extent and nature of work and care arrangements, the adequacy of current support systems, and effective work and care policies and practices in place in Australia, for these particular groups. We also make comments, where relevant, to the healthcare workforce that supports mental health consumers and family carers.

We welcome the opportunity to provide our submission on the Employment White Paper Consultation to assist in the mapping of a comprehensive blueprint for Australia's future labour market. We have made comments within each of the 6 terms of reference areas, though recognise that several of our comments are applicable and have inherent linkages across the various terms of reference, due to the nature of issues of concern and importance in relation to employment and mental health and disability.

Feedback on the Terms of Reference

1. Full employment and increasing labour productivity growth and incomes, including the approach to achieving these objectives.

Full employment is a key area of concern for people with mental health challenges and their family carers and kin because of the significant broad reaching impacts and effort required in managing either the episodic and unpredictable nature of mental illness or because of the high demands of managing ongoing psychosocial disability related to mental health and the expectations of the workplace. Many employment structures are not sufficiently flexible to accommodate these circumstances for people with mental ill-health and disability. It's often an all or nothing experience which means that consistent full employment is a real challenge, and aspirational rather than a reality. This is true for many people managing their own mental health and for family carers supporting others. This situation creates lost opportunities for these individuals to contribute their skills and expertise within employed roles.

LEA urges the Employment Taskforce to consider the definition of 'full employment' and 'part-time employment' and the various conditions associated with these, as this may differ for individuals with disability and for family carers.

Like many in the community, people with mental health challenges come from all walks of life, with many having qualifications, careers, skills and experience that are and could be of great benefit to the Australian economy, workplaces and the community. However, unemployment, underemployment, casualisation of labour and often being employed in menial roles that do not match their skills and qualifications are common. There are many reasons for this, and we describe this in more detail under TOR 5 below. Our key concern is the wasted opportunities to contribute

that arise from these circumstances and particularly the waste with regard to return on investment. An analogy is the concerns related to transition from the military for veterans, for example, where significant money, time and effort goes into training them so it would make sense economically to address structures to ensure that their skills and expertise and contribution can continue after their service. Many people with mental health challenges undertake training, study and hold trade and tertiary qualifications but many are unable to use those qualifications and skills because employment systems are not sufficiently flexible to include them and support them in ongoing employment that also accommodates their health and/or disability needs.

These concerns also apply to family carers. We know from our many consultations with family and kin of people with mental health challenges that, like the general demographic, mental health carers who are in employment are striving to remain in employment for as long as possible, whilst trying to balance their caring role. We also know that, like the general demographic, their adult offspring are remaining at home for longer, often well into their 20s. Of specific note, for mental health carers, this population has disproportionate experience of continuing their carer roles of adult children with mental health challenges beyond this early adult period. Many people with mental health challenges develop these challenges in their teen years, and family carers may be in the role of primary carer for decades, with the person remaining living in the family home or living nearby either independently or in supported accommodation, whilst others live quite independently and well with their mental health. Either way, many individuals remain strongly linked to their family carer for ongoing emotional and practical support. This can be for activities of daily living, problem-solving life issues that arise, regular emotional and practical support, and intermittent financial and transport support.

We know that there are many individuals with psychosocial disability who do not receive NDIS support, either because they are deemed ineligible, having pursued an application, or have had their application rejected. Even when their family member has an NDIS package, whether self-managed or plan managed by an NDIS provider, family carers are routinely drawn into an active role because of problems within the NDIS system regarding the skills and behaviours of support staff, inconsistencies in billing, and various issues re the coordination of care. Beyond the demands of the caring role itself, which itself can put pressure on carers to maintain their employment, the promise of NDIS support making life easier for family carers has not necessarily occurred for many of them.

LEA believes that a significant focus of the Employment Taskforce's work must be on how employment systems and workplaces can create the conditions for maximising and preserving full employment for employees with disabilities and also people with carer responsibilities. This maximises return on investment by the person, the employers and the community.

2. The future of work and labour market implications of structural change, with a focus on building a sustainable care economy in the context of an ageing population and other drivers of demand for care services:

There is a noticeable increasing policy and practice focus on the mental health and wellbeing of the Australian community and workplaces, in general. However, there are also significant concerns about the current and future supply of the healthcare workforce and its ability to meet that demand. A report by Deloitte (2022) has predicted a shortfall of 11,392 FTE general practitioners (GPs) by 2032, which is equivalent to 27.9% of that workforce. LEA recognises the significant role that GPs play in the lives of people with mental health challenges and their family carers. GPs are often the first and last option, and the most reliable and accessible option, for people seeking support for their mental health. Across our many research projects asking consumers and carers about their experiences of care, it is clear that GPs are highly valued and trusted because they deliver care that is highly person-centred and holistic, and they are more likely to attend to both the physical

health and mental health care needs of the individual where other workforces are more siloed in their approach. This is significant given the rates of comorbid physical health and mental health conditions for people with severe mental ill-health remain far higher than the general population and they continue to die much sooner than they should, largely from preventable physical health conditions.

LEA believes that a significant focus of the Employment Taskforce's work should be on actions and strategies to address future healthcare workforce concerns, particularly GP shortages.

Projections published in a recently released National Skills Commission (2022) report are that around 531,600 full-time equivalent (FTE) care and support workers will be required by 2049-50. LEA recognises the significant role that care and support workers play in delivering support to people with mental health challenges in a range of clinical and community managed organisation contexts, and to people with psychosocial disability through the NDIS system, in particular, but also more broadly within health and social care services.

Within the care and support workforce, the lived experience (peer) workforce has been well established in academic literature as a cost-effective augmentation of the existing care economy. Peer Workers are people with lived experience of mental ill-health, intentionally employed to use their experience of recovery in the delivery of mental health support (Chinman et al., 2014). They 'walk alongside' mental health consumers to improve their self-efficacy by sharing with them their own experience of personal recovery, and by supporting their sense of resilience, connectedness, hope, identity, meaning and empowerment (Leamy et al., 2011). The relationship is centred on mutuality, equality and reciprocity (Stratford et al., 2019). Peers also promote the person's trust and engagement with services (Repper & Carter, 2011). Peer support includes practical and emotional support, positive self-disclosure, expansion of social networks, education, information, and advocacy. This support is currently provided in settings including outreach, inpatient units, community and day programs, telephone support and Emergency Departments (Stratford et al., 2019; Brasier et al, 2022). Peers connect people with services and community activities, help address stigma and self-stigma, help people translate and adapt services to their individual needs, and build self-efficacy and quality of life. Their presence also helps transform services to be more consumer-focused and recovery-orientated (Byrne et al, 2021).

The recent Productivity Commission Inquiry into mental health (2020) found that peer workers: instil hope in recovery; actively model self-care and self-management strategies; actively foster trust, understanding and empathy, and; provide insight into the complexities of navigating the mental health system for both employers and the consumer and carers they are employed to support. LEA notes that there is no mention of peer workers or the peer workforce within the consultation documents, or reference to the development of the lived experience workforce in relation to the building of a sustainable care economy.

LEA believes a greater emphasis on the peer workforce should be reflected throughout this Consultation. Peer workforce is the fastest growing area in the mental health provider space and needs to be formally acknowledged and targeted for supported development. This development must include the establishment of a professional organisation for this workforce, and safety and quality standards specific to that workforce.

3. Job security, fair pay and conditions, including the role of workplace relations.

We know that mental health consumers and carers who also work in paid employment have many pressures in juggling the unique challenges of maintaining work-life-health balance. This can have particular impacts on the number of hours they can work, and potential restrictions on their availability and flexibility in the type of shifts that they can work. This can adversely impact their job security and prospects of promotion or pursuit of career. It can also impact the conditions of work, where they may accept or tolerate poorer work conditions because they feel they have less 'bargaining' power due to the flexibility required to also focus on self-care and self-management of

intersectional and psychosocial stressors. There may be fewer protections for this population and, rather than say anything, they may simply put up with the existing conditions or leave. We know that many mental health consumers and carers who work are in lower paid roles that may or may not match their qualifications, training or skills.

The COVID pandemic has taught us all that many jobs can be performed from home and that doing so does not reduce people's productivity. In fact, it may increase it. Carers who are also employed in paid roles, in particular, have valued these flexible arrangements. Equally though, we recognised that working from home doesn't suit all, and some people may value being away from their home environment and at work, to connect with others. To reiterate, work can serve as an important form of social connection, particularly for people with mental health challenges who may have small social networks and connections with their community. Work is also incredibly important for their sense of recovery and self-worth. Equally, work can be an important source of 'respite' for some family carers, given the rigors of their caring role.

4. Pay equity, including the gender pay gap, equal opportunities for women and the benefits of a more inclusive workforce.

We know that the financial burden of concurrently managing mental health challenges against inflexible workplace demands and the rising cost of living can take a significant toll. Consultations with mental health consumers have revealed that their capacity to work full-time can be severely limited by the demands of attention specialist appointments and treatment clinics that only operate during business hours. A growing trend of lived experience advocates working from home around contract and consultation models has been noted in order to allow for alternative income streams whilst managing the particular nuances of their own mental health self-management.

We know that the vast majority of mental health carers identify as women. Hence, the many potential impacts of juggling paid work and the caring role are likely to impact women disproportionately. This has implications for them experiencing lower household income, smaller superannuation nest eggs, greater disruption to careers, less opportunities for promotion, and so forth. In regional and rural areas where the diversity of work options may be more limited, these impacts are likely to be even greater.

Recognition of the need for carer leave as a standard component of paid leave from work has gone some way to alleviating the needs of carers in paid employment to also juggle their informal carer roles, and this is very much appreciated. The Productivity Commission consultation has opened up the dialogue to the potential for thinking more creatively and differently about how individuals may be supported better in their navigation and achievement of their valuable work roles.

A basic minimum wage is needed.

5. Labour force participation, labour supply and improving employment opportunities.

People with current and past experience of mental health challenges are likely to experience significant adverse impacts from multiple social determinants of health such as a history of disruption to education, unsafe and insecure housing, poverty, family violence and so forth. Their futures can also be complex and uncertain as they build their recovery path despite multiple barriers and challenges (taken for granted stability in social determinants and secure core conditions for getting a job and keeping a job).

In relation to workplace readiness, the structure of current arrangements demands that the person is either ready or non-ready; however, the path to developing skills, capabilities and confidence must be considered. This can be long, disrupted and diverse.

The Productivity Commission report provides detail of a number of hybrid models of employment shown to fit will with people with psychosocial disability and with mental health challenges.

We urge the Employment Taskforce to review the PC findings and its important insights and recommendations on employment in relation to mental health and disability.

As stated in relation to TOR 1 above, many people with mental health challenges have higher level qualifications than the menial jobs that they find themselves being forced to do. This is a missed opportunity on many levels. Also, it means that the creativity and diversity and innovation required to respond to the challenges we all face as a community may be stifled.

A key element to being more inclusive is ensuring a focus on workplace adjustments, eg., flexibility regarding hospital and medical appointments, that would support labour force participation, tenure and retention.

Another key element involves ensuring equity and non-discrimination as part of the return-to-work process. For example, Wellness plans are potentially discriminatory and stigmatising where they single out individuals with mental ill-health or disabilities of any kind. Related to this are 3-month probation discrimination issues regarding the questions being asked currently about the person's mental health and disability status, which is discriminatory and inequitable. **There need to be wider workforce rules that apply to all, consistently and fairly.**

A further key issue is that there is currently no incentive to work on the Disability Support Pension. Centrelink's requirement for fortnightly reporting is stressful, time-consuming, and is laden with bureaucratic processes that are self-serving and do not actually support the transition to employment.

LEA urges the Employment Taskforce to pay close attention to the lost opportunities for workforce participation that arise from the longitudinal impacts of adversity and complex social determinants and also overly bureaucratic structures that keep people unemployed and under-employed.

In a recent submission in relation to the National Mental Health Workforce strategy, LEA also made the following observations about specific groups in the community:

- Rural and remote workforce issues need to receive greater attention. We know that people living in rural Australia are less likely than those in *Major cities* to have completed Year 12 or a non-school qualification, less likely to have University qualification, and more likely to head to capitals for education (*away from family supports*), and they are less likely to be employed – and have a smaller range of employment and career opportunities (ABS 2022). Also, they generally have lower incomes but pay higher prices for goods and services - 19% less household income per week compared with those living in capital cities, and 30% less mean household net worth (ABS 2022). We also believe that FIFO workers and the impact of their presence on the communities could have a greater focus, especially given sustainability of communities are integrally linked with employment structures, families and ongoing connection with place.

The reliability and accessibility of good mental health support and other critical infrastructure to keep communities thriving in rural Australia is a major issue for these areas currently and must be addressed with a greater focus on these areas going forward.

- Veterans' and first responders' mental health needs do not have a great focus in discussion about employment, yet we know that many good skilled people leave these professionals after only a few years. More should be done to understand and support stronger more consistent tenure so that their value, skills and experience isn't lost.

- CALD and refugee focused workforce and skills issues in these areas. With the situation in Afghanistan and the increased numbers of asylum seekers and refugees, this area will increase.
- Climate change also will likely increase issues and its mental health impacts for broad and specific populations will also grow; this will have significant impacts for employment and the nature of work into the future.

LEA also acknowledges that stigma exists for people who live with mental health challenges across many sectors and structures in the community, despite many national campaigns to reduce or eliminate it. With the National Stigma and Discrimination Reduction Strategy due to be finalised by the National Mental Health Commission in 2023, **LEA also maintains that targeted work is required to demonstrate that workplaces are a safe, efficient, and attractive places for employee engagement, inclusive of people with mental health challenges.**

Further, we acknowledge that many professionals choose to work in mental health clinical workplaces because they want to make improvements to peoples' lives and assist mental health recovery. This plays a crucial role, and the mental health professional workforce needs to have the same respect as any other area of medicine. LEA believes that stigma by the workforce, and the holding of low expectations of employment toward consumers, remain a focus of consultation in eradicating discrimination that represents ongoing barriers to employment for consumers.

We urge you to consider bilateral federal and state agreements that include unilateral access to important opportunities for people with mental health challenges and psychosocial disability to build their capacity for participation in work, study and community engaged contributions, more broadly. Recovery Colleges are a prime example of this opportunity; however, they are not currently available in each jurisdiction (ACT does not have a Recovery College and access to them is limited to major metropolitan centres). Evaluation research that we and others have undertaken has clearly established the value of Recovery Colleges (Muir-Cochrane et al, 2019). They provide a transition space for shifting learners' identities from patient to student…providing hope for the future. This study highlights the importance of providing mentally healthy and non-stigmatizing learning environments to promote and cement recovery for people with a lived experience of mental illness (Muir-Cochrane et al, 2019).

In relation to labour force participation, supply and improving employment opportunities LEA maintains that it is imperative that these observations and how they also relate to people with mental health challenges and disabilities need to remain central in ongoing workforce development.

6. The role of collaborative partnerships between governments, industry, unions, civil society groups and communities, including place-based approaches.

LEA supports collaboration with policy makers, educators and administrators including the sustainable development and scaling of the lived experience workforce. Additionally, collaboration in the broader mental health context and in the building of a sustainable care economy is crucial and the needs across Commonwealth, state/territories, professional colleges and organisations is a focus LEA strongly supports. Without this focus, the workforce alone will struggle to make meaningful changes to attitudes, embedded clinical culture etc. LEA believes the workforce must match the needs of the community in which it exists, and this varies e.g. First Nations communities and rural and remote versus city centric services.

LEA again refers to the urgent need for a national member based professional organisation for the peer workforce. One of the tasks would be exactly this, i.e., defining scope of practice, roles and

responsibilities, offering professional development, training and education, supervision and a nationally consistent remuneration system.

7. Other relevant topics and approaches.

The needs of consumers and carers in relation to employment and workforce engagement are diverse and therefore likely require diverse solutions. LEA would like to stress that targeted legislative and structural reform regarding the maintenance of discriminatory attitudes that have traditionally led to the exclusion of mental health consumers and carers in workplace engagement also be considered as a point of revision. Lived experience workers in non-clinical, clinical and wider workforce engagement are able to play a vital role in meaningfully increasing living standards for more Australians if we are adequately and sustainably supported to do so.

Among the solutions are the need to train clinical workforce in being trauma-informed regarding their work alongside the peer workforce and the need for better training of employment services staff regarding the needs of the disability sector.

We do also believe that there is value in and a need to educate employers about the impacts of juggling work and care on consumers and carers and how employers can better support staff. Some employers are very flexible and supportive; however, we are aware that there are adverse impacts for some because the employer does not understand the need for flexibility and the benefits this can create for their workforce (increased productivity and commitment).

Clearer Job and Person Specifications for Lived Experience roles – The current lack of clarity and consistency creates insecurity and uncertainly in the delivery of the role, and also impacts other aspects such as future employment (superannuation and leave arrangements, for example) which can be lost with multiple job changes and casualisation of the workforce.

For people with psychosis/schizophrenia diagnosis, in particular, the statistics across many countries and including Australia, for unemployment, longstanding unemployment, and never achieving employment experience are appalling – approximately three quarters are unemployed.

A particular area for consideration is employment opportunity where the person has a criminal record. The lived experience workforce, in particular, is founded on the strength and mutuality of lived experience and the trust that this engendered in the delivery of services and people's engagement with service systems. Some people with lived experience who have turned their lives around and are committed to improving the lives of others who would be of great value in certain employed roles do have criminal records e.g. homelessness services, drug and alcohol services, Family violence, recidivism prevention and early intervention services, etc. Current employment structures make it difficult (or impossible) for them to take up such employment. As the mental health and social welfare sectors, in particular, increasingly focus on the value of lived experience workforce, this tension is likely to increase and so work to resolve it is important.

The COVID-19 pandemic also had unintended impacts on employment for people in contact with Centrelink due to many staff new to the roles but with insufficient training, skills, knowledge and experience regarding mental health and disability.

Contact

We thank the Employment Taskforce for the work it is doing on this important national issue. We wish you every success with the next steps. We would be keen to discuss further, any clarification or issues raised here with you.

Your sincerely

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References:

ABS (2022) *Labour force, Australia, detailed*, ABS website.

Brasier C, Roennfeldt H, Hamilton B, et al. Peer support work for people experiencing mental distress attending the emergency department: Exploring the potential. *Emerg Med Australas* 2022;34(1):78-84.

Byrne, L., Wang, L., Roennfeldt, H., et al. (2021) National Lived Experience Workforce Guidelines. National Mental Health Commission. https://www.mentalhealthcommission.gov.au/lived-experience/lived-experience-workforces/peer-experience-workforce-guidelines

Chinman M, George P, Dougherty RH, et al. Peer support services for individuals with serious mental illnesses: assessing the evidence. *Psychiatr Serv* 2014;65(4):429-41.

Deloitte (2022) General Practitioner workforce report 2022. Prepared for Cornerstone Health Pty Ltd May 2022. https://www2.deloitte.com/content/dam/Deloitte/au/Documents/Economics/deloitte-au-cornerstone-health-gp-workforce-06052022.pdf

Leamy M, Bird V, Le Boutillier C, et al. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *Br J Psychiatry* 2011;199(6):445-52.

Muir-Cochrane, E., Lawn, S., Coveney, J., Zabeen, S., Kortman, B., Oster, C. (2019) The Recovery College as a transition space in the journey towards recovery: A qualitative exploratory study. Nursing and Health Sciences. 21(4), 523-530. https://onlinelibrary.wiley.com/doi/10.1111/nhs.12637

National Skills Commission (2022) Care Workforce Labour Market Study. Report Summary. https://www.nationalskillscommission.gov.au/sites/default/files/2022-10/care_workforce_labour_market_study_-_report_summary.pdf

Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra

Repper J, Carter T. A review of the literature on peer support in mental health services. *J Ment Health* 2011;20(4):392-411.

Stratford AC, Halpin M, Phillips K, et al. The growth of peer support: an international charter. *J Ment Health* 2019;28(6):627-32.