University Library

A gateway to Melbourne's research publications

Minerva Access is the Institutional Repository of The University of Melbourne

Author/s:
Devine, Alexandra Elizabeth Fraser

Title:
‘I’m proud of how far I’ve come. I’m just ready to work.’ Exploring the relationships between the life circumstances of people with psychosocial disability and their engagement with the Australian Disability Employment Services program

Date:
2020

Persistent Link:
https://hdl.handle.net/11343/243032

Terms and Conditions:
Terms and Conditions: Copyright in works deposited in Minerva Access is retained by the copyright owner. The work may not be altered without permission from the copyright owner. Readers may only download, print and save electronic copies of whole works for their own personal non-commercial use. Any use that exceeds these limits requires permission from the copyright owner. Attribution is essential when quoting or paraphrasing from these works.

‘I’m proud of how far I’ve come. I’m just ready to work.’

Exploring the relationships between the life circumstances of people with psychosocial disability and their engagement with the Australian Disability Employment Services program.

Alexandra Devine

Submitted in total fulfilment of the requirements of the degree of Doctor of Philosophy

September 2020

Centre for Health Equity

Melbourne School of Population and Global Health

Faculty of Medicine, Dentistry and Health Sciences

The University of Melbourne

ORCID: 0000-0002-7549-9876

This page is intentionally blank

Abstract

Participation in decent work is recognised as central to supporting individuals, with and without disabilities, to attain socio-economic opportunities, and, health and well-being. Through their ratification of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), Australia has committed to supporting people with disabilities realise their right to work. Yet, Australians with disabilities continue to experience significantly poorer employment outcomes when compared to Australians without disabilities. Among those with disabilities, people with psychosocial disability experience some of the lowest levels of employment. Challenging life circumstances, intertwined with vocational and non-vocational barriers to employment, are recognised as both causes and consequences of poorer employment outcomes.

The Australian Disability Employment Services (DES) program, is the federal government's specialised welfare program for people whose disability is assessed as their main barrier to employment. Over recent decades, continual reform has seen the DES program transition from a publicly-funded and delivered program to a quasi-market of government contracted for-profit and non-profit businesses who support and monitor the efforts of people with disabilities in receipt of income support (and a small number of voluntary participants) to actively promote their employability and participation in work. Under the current reforms, implemented in July 2018, DES participants have been given more choice and control to determine which provider they use and to change providers if they are not satisfied. It is assumed that these reforms will incentivise DES providers to be more responsive to participants' needs, ultimately leading to improved employment outcomes.

Drawing on survey data from 369 respondents with disabilities engaged with government funded employment services, and, qualitative interviews conducted at two time points with 30 DES participants with psychosocial disability (total 56 interviews), this thesis explored the perspectives of these participants on how their life circumstances influence and/or are influenced by their engagement with the DES program, in the context of the current reforms.

The findings suggest that despite considerable investment and reform, the DES program struggles to address the significant and complex barriers to employment experienced by DES participants with psychosocial disability. Addressing these barriers requires broader social policy investment. Until this is achieved, the effectiveness of the DES program will continue to be undermined.

Declaration

I, Alexandra Elizabeth Fraser Devine, declare:

i) The thesis comprises only my original work towards the Doctor of Philosophy except where indicated in the Preface

ii) Due acknowledgement has been made in the text to all other material used

iii) The thesis is fewer than 100,000 words in length, exclusive of tables, bibliography and appendices.

Signed:

Alexandra Devine

Date: 15 of September, 2020

Prologue – Simon's story

Simon grew up with his parents in an outer suburb of Melbourne. He excelled at school whilst working on the weekends, and, went on to complete a Bachelor of Commerce. Simon attributes the volatile breakdown of his parents' marriage during his time at university, as a significant contributor to his decline in mental health, and, as the trigger of his Obsessive Compulsive Disorder. Nonetheless, Simon embarked on a career with a bank, married, and started a family of his own.

After a few years at the bank, Simon resigned. He could no longer cope with sharing work spaces and facilities with colleagues or customers. He was also struggling to not let his OCD impact on the relationship with his wife and children. Simon began to emotionally and physically retreat to the point where he rarely left the house. Compounded by the side-effects of medication, his physical health also deteriorated. Much of his time was spent contemplating suicide, describing that his strong faith in religion and the love he felt for his family kept him loosely tethered to this life.

Simon's marriage survived for twenty years, yet his distrust in people didn't make for an easy relationship. A confrontation with his son was a turning point, and, he was asked to leave the family home. The couple agreed to divorce and Simon moved in with his sister. His sister encouraged him to re-connect with his local church, where he found the priest to be of immense support. Not wanting to be under his sister's feet all day and finding more energy after a change in medication, Simon started walking, building up to eight kilometres a day.

It was on one of these walks that he stumbled across a Disability Employment Service. By this stage, Simon hadn't worked for seventeen years. He quickly established a positive relationship with his DES worker, identifying a pathway towards a long-term aspiration to find volunteer or paid work as a financial counsellor. The DES worker helped Simon enrol in further education and provided a small amount of funding to cover some of the costs.

Part way through his studies, his sister suggested it was time for him to move out. With nowhere else to go, Simon stayed in his car, moving from suburb to suburb in search of a safe place to park and sleep. This was not always possible and he was admitted to hospital after being attacked. On another occasion he was also admitted after sustaining third degree sunburn after falling asleep on the beach. Despite these setbacks, Simon continued to complete his studies, on his mobile phone in the front seat of his car, holding onto the hope that one day he would find work, and his life would become a little easier.

Preface

This thesis is submitted as a 'PhD with publications'. Alongside the standard chapters outlining the introduction, context, conceptual framing, methods and discussion, this thesis includes three peer-reviewed journal articles, and, one discussant reviewed conference paper as my results chapters. It should be noted that depending on the time of submission and publication, some background data presented may differ slightly between the papers. My supervisors and colleagues contributed to all of these publications, with my contribution to each paper exceeding the 85 per cent requirement.

The publication status and contribution of co-authors are as follows:

- Chapter Six: Devine, A., Kavanagh, A., & Vaughan, C. (2020). *'If I had stable housing I would be a bit more receptive to having a job.'* Factors influencing the effectiveness of Disability Employment Services reform. *WORK: A Journal of Prevention, Assessment, and Rehabilitation* (accepted 21 August 2019, due to be published in Volume 65(4), April 2020).

  I was responsible for the design, implementation and analysis of the research informing this paper, and, writing of the paper, under the guidance of my supervisors. My supervisors and co-authors, Professor Anne Kavanagh (Primary) and Associate Professor Cathy Vaughan (Co-supervisor), reviewed a sample of interview transcripts to ensure the appropriateness of the analysis framework, and, reviewed drafts of the submitted manuscript.

- Chapter Seven: Devine, A., Vaughan, C., Byars, S., & Kavanagh, A., (2019). How disability and welfare policies interact to influence the right to work of people with psychosocial disability. This paper was accepted as conference proceedings for the *Fourth International Conference on Public Policy*, Montréal, in June 2019. It was presented in the panel entitled Public Policy Approaches to Protecting and Enhancing the Rights of Persons with Disabilities, chaired by the WORLD Policy Analysis Centre at the University of California Los Angeles (UCLA).

  This is a mixed methods paper, drawing on quantitative survey data from the Australian Research Council (ARC) Linkage Project *Improving Disability Employment Study (IDES)*, in which my PhD is embedded, and, qualitative data conducted as part of my PhD. My Primary supervisor, Professor Kavanagh, is the Chief Investigator on the IDES project and developed the project protocol, with the support of my Co-supervisor and IDES project Co-investigator, Associate Professor Vaughan. I contributed to the IDES survey design, which was

implemented by the Social Research Centre. Co-author Dr Sean Byars joined the IDES team after the survey was in the field. Professor Kavanagh and Dr Byars provided guidance and cross-checked my quantitative analysis of the IDES survey data. I was responsible for the design, implementation and analyse of the data from the qualitative interviews drawn upon in this paper, under the supervision of Associate Professor Vaughan. All co-authors reviewed drafts of the manuscript submitted.

- Chapter Eight: Devine, A., Dickinson, H., Brophy, L., Kavanagh, A., & Vaughan, C. (2019): '*I don't think they trust the choices I will make.'* – Narrative analysis of choice and control for people with psychosocial disability within reform of the Australian Disability Employment Services program. *Public Management Review* August 2019, DOI: 10.1080/14719037.2019.1648700.

  This paper draws on the qualitative interviews conducted as part of my PhD. I was responsible for the design, implementation, analysis and writing for this publication, under the guidance of my supervisors. Professor Helen Dickinson provided specific guidance on conducting narrative analysis within the social policy context. Professor Lisa Brophy provided guidance on contextualising psychosocial disability and choice and control within the analysis.

- Chapter Nine: Devine, A., Vaughan, C., Kavanagh, A., Dickinson, H., Byars, S., Dimov, S., Gye, B., & Brophy, L. (2020). *'I'm proud of how far I've come. I'm just ready to work'*: mental health recovery narratives within the context of Australia's Disability Employment Services. *BMC Public Health* 20, 325, March 2020, https://doi.org/10.1186/s12889-020-8452-z.

  This is a mixed methods paper drawing on IDES quantitative survey data, and the qualitative interviews conducted as part of my PhD as described above. Professor Kavanagh, Dr Byars and Ms Stefanie Dimov (IDES project manager), provided guidance and cross-checked the quantitative analysis. Associate Professor Vaughan, Professor Dickinson and Professor Lisa Brophy provided guidance on the qualitative analysis focused on personal recovery. Mr Bill Gye was the Chief Executive Office at the DES provider which financially supported my PhD. During his time in this role, Mr Gye provided guidance to ensure my interpretation of findings were appropriately grounded and informed by the current DES context. All authors reviewed drafts of the paper prior to submission.

Key acronyms and definitions

ABS	Australian Bureau of Statistics
ABS SDAC	Australian Bureau of Statistics Survey of Disability, Ageing and Carers
AFDO	Australian Federation of Disability Organisations
AHRC	Australian Human Rights Commission
AIHW	Australian Institute of Health & Welfare
Benchmark hours	Number of hours income support recipients are assessed as currently capable of working or being able to work with appropriate support.
Centrelink	Main welfare interface of the Australian Government's Department of Human Service, responsible for assessing eligibility of welfare programs, referring participants into employment services programs, and, administering social security payments (aka. income support payments, pensions)
COAG	Council of Australian Governments
DES	Disability Employment Services: sitting within the broader welfare system, the DES program is the Australian federal government's main employment services program for income support recipients (and some voluntary participants) for whom disability is assessed as their main barrier to gaining and maintaining employment. DES are comprised of two main streams, DES-DMS and DES-ESS.
DES-DMS	Disability Employment Services - Disability Management Support: DES program stream for participants with an injury, health condition or disability, requiring support to find and/or maintain work. DES-DMS participants usually only require occasional support to stay in work.
DES-ESS	Disability Employment Services - Employment Support Service provides support and assistance to people living with a permanent or long term disability or health condition to find and maintain work. DES-ESS participants usually require a higher level of ongoing support.
DES frontline worker	DES staff member providing direct assistance to DES participants. Significant variation exists in the skills and expertise of workers as no formal qualifications or skills standards are required to perform the role (aka employment consultant).
DEEWAR	Department of Education, Employment and Workplace Relations was a former Department of the Australian federal government. After various iterations and as of the time of writing, is now known as the Department of Education, Skills and Employment (DESE). DESE oversees the mainstream *jobactive* employment program.
Disability	People with disabilities are conceptualised as '*those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others*.' (UN General Assembly, 2006, p. 4 Art. 1).
DSP	The Disability Support Pension is the Australian Government's pension for individuals with a permanent physical, intellectual or psychosocial condition who are unable to work or with a substantially reduced capacity to work. DSP participants under the age of 35 may still be required to engage with the DES

	program, if they are assessed as being able (with capacity building and support) to work at least eight hours or more per week.
DSS	Department of Social Services is the Australian Government's main Department responsible for the administration of national social policies and programs. DSS oversees the current DES program.
IDES	*Improving Disability Employment Study*: Australian Research Council Linkage Grant project implemented by the University of Melbourne in partnership with disability and employment provider peak bodies, employment service providers, and disability advocacy bodies. The IDES team also includes academic partners from Deakin University and PriceWaterhouseCoppers.
IPS	Individual Placement and Support
jobactive	Australian Government's main employment program for income support recipients whose main barrier to employment is not assessed as disability. Overseen by the Department of Education, Skills and Employment.
MHI-5	Mental Health Inventory (MHI-5), a subscale of the Short form-36 (SF-36) General Health Measure. Validated as a screening tool to detect symptoms of anxiety, depression, behaviour control, positive affect and general distress in the past four weeks.
NDIS	Trialled in 2013 and rolled out nationally in 2017, the National Disability Insurance Scheme is the Australian Government's program to publicly fund the support of people with a 'permanent and significant' disability (under the age of 65), for 'reasonable and necessary' supports and services, related to their disability (subject to certain restrictions), through individualised budgets to achieve self-determined goals. In 2019, the Australian Government established a government Minister to help oversee the NDIS in collaboration with the Department of Social Services, and, the National Disability Insurance Agency (NDIA).
NPM	New Public Management
Newstart Allowance	Main income support payment for Australians who are unemployed. To receive the payment, individuals must be over the age of 22 but under the age set for the aged pension, looking for work, under the income and assets test level, and, prepared to meet mutual obligation requirements.
PWI	Personal Wellbeing Index (PWI). A seven item validated measure of subjective well-being eliciting respondent satisfaction across domains of standard of living, health, achieving in life, relationships, safety, community connectedness, and, future security.
Psychosocial disability	Disability associated with the lived experiences of mental illness, noting not all people who have a mental illness have a disability.

TAFE	Technical and Further Education. Australian national terminology for the technical and vocational education sector.
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities.

Acknowledgements

I have contemplated often on reaching the point in the PhD journey when I could write these acknowledgements and reflect on the many people that have made this journey both possible and enjoyable. It's lovely to be here. Firstly, I acknowledge and pay my respects to the Wurundjeri people of the Kulin Nation, as the custodians of the land upon which this research took place, and, where I live and work. Their knowledge, connection and long history with this land is something that inspires me every day.

My sincere thanks to all the people that participated in this study. I have carried the stories you shared with me for some time now. I am constantly learning from your experiences and advice: from strategies of parenting a middle child, to the importance of supporting the mental health and well-being of all individuals in our communities. Thank you.

I was incredibly fortunate to be supervised by Professor Anne Kavanagh and Associate Professor Cathy Vaughan, whose commitment to research that improves the lives of people who experience disadvantage is second to none. I have learnt so much from working with you both and look forward to continuing to do so. I was equally lucky to have Professor Lisa Brophy and Professor Helen Dickinson on my advisory committee. Alongside my supervisors, their expertise and guidance played a huge role in shaping the direction of my research.

I would like to thank the IDES research team for enabling me to conduct my research as part of the project, with special thanks to Stefanie Dimov for your tireless work in keeping the project on track, and, to Sean Byars for your guidance with my analysis. I would also like to acknowledge the late Associate Professor Allison Milner for your immense contributions to IDES and the wider work of the Disability & Health Unit. I am so sorry I didn't get to work with you for longer.

My research was supported by Ostara and their leader at the time Bill Gye. Bill and his team were incredibly welcoming of me and taught me so much about DES. Bill in particular was a wealth of knowledge on everything to do with mental health and recovery. I will be forever indebted to him for sharing some of this knowledge with me. I also had an unofficial advisory committee in Dave Peters and Georgia Katsikis who continually helped ground my research through their knowledge and experiences.

Big thanks to all in the Disability & Health Unit, with particular thanks to Mellissa Kavanagh, Marissa Shields, Anne-Marie Bollier, Zoe Aitkens and Ashley McAllister for all your statistical and editing advice and support over the last three years, and, to George Disney for your knowledge and good

humour. I would also like to thank my fellow colleagues and PhD students down the corridor, who have been a constant source of all that is needed to complete a PhD. Special thanks to Liz Gill-Atkinson, Tessa Hall and Yamna Taouk in this regard.

I have been with the Nossal Institute for Global Health for nearly 15 years. Over that time I have worked with so many incredible people that have been instrumental to my research and life journey. It is impossible to thank them all, but I would like to single out Beth Sprunt, Sally Baker, Michelle Kermode, Alison Morgan, Peter Deutschmann, Aleisha Carroll, and Manjula Marella for throwing me in the deep end of research into mental health, North-East India, and disability all those years ago, and, encouraging and helping me to learn to swim my way through it. More recently I have been so well supported by everyone in the Disability Inclusion for Health and Development Unit led by Alex Robinson and the wider folks at Nossal, for which I am extraordinarily grateful.

Thirteen years ago, my research focus on disability collided with the birth of my first child. Oliver continues to be a significant driver in both my work and daily life to promote the rights of people with disabilities. In this (and my thesis), I am totally indebted to the support of my partner Roger, and our children Oliver, Leah and Ralph. Together, we are supported by a huge tribe of family, friends, teachers, communities and therapists. Special thanks to my mum, Julie and John Devine, and, the Thomson and Devine clans. This is alongside our heartfelt thanks to Chris Devine, Daphne Proietto, Kathryn Kolmorgan, Hailey Lowe, Robyn Byrne, Claire Tighe and Ciara Chaomhanach for your support of Oliver and us. Big thanks to everyone at the Bellfield Community Gardens for all that you do. And, finally, to the Parcell, Mason, Smith, Short, Dam Anderson, O'Mullane, Roberts, Broomfield, Oliver, Merrigan, Ralton, Group Dinner, Dayal, Yeates and Fryat families for your friendship and support, and, for remembering to pick up my kids from ballet on the occasions when the PhD invaded the family logistic head space.

Table of Contents

Abstract i
Declaration ii
Prologue – Simon's story iii
Preface iv
Key acronyms and definitions vi
Acknowledgements ix
Table of Contents xi
Chapter One. Introduction 1
1.1 Overview and context 1
1.2 The current thesis 2
1.3 Overview of methods 3
1.4 Outline of thesis 4
1.5 Implications for policy and practice 5
Chapter Two: Conceptualising psychosocial disability in the Australian context 6
2.1 Conceptualising psychosocial disability 6
2.2 Continuum of mental distress and psychosocial disability 7
2.3 The rights of people with disabilities 8
2.4 Social determinants of psychosocial disability 10
2.5 Prevalence and health implications of mental illness and psychosocial disability 11
2.6 Costs and resourcing of mental health systems 12
2.7 Disability and work 14
Chapter Three: Reforming Australia's Disability Employment Services 17
3.1 The evolution of the Disability Employment Services program 17
3.2 Current federal government employment services 18
3.3 Calls for reform 21
3.4 The latest DES reform and the ongoing influence of New Public Management 23
3.5 Increasing emphasis on 'activation' within Australia's social security system 26
Chapter Four: Conceptual framing 29
4.1 Szymanski and Hershenson's Ecological Model for Vocational Behaviour and Intervention for People with Disabilities. 29
4.2 The CHIME Personal Recovery Model 36
Chapter Five: Methods 43
5.1 Research questions 43
5.2 Mixed methods interpretivism and approach 44
5.3 Quantitative methods 45
5.4 Qualitative methods 52

5.5 Participant demographics 57
Chapter Six: 'If I had stable housing I would be a bit more receptive to having a job.' 61
6.1 Introduction 62
6.2 Methods 66
6.3 Results 67
6.4 Discussion 77
6.5 Conclusion 78
Chapter Seven: How disability and welfare policies interact to influence the right to work of people with psychosocial disability. 80
7.1 Introduction 81
7.2 Methods 85
7.3 Findings 87
7.4 Discussion 96
7.5 Conclusion 99
Chapter Eight: 'I don't think they trust the choices I will make.' 102
8.1 Introduction 103
8.2 Methods 107
8.3 Findings 109
8.4 Discussion 119
8.5 Conclusion 123
Chapter Nine: 'I'm proud of how far I've come. I'm just ready to work' 125
9.1 Introduction 126
9.2 Methods 131
9.3 Results 135
9.4 Discussion 148
9.6 Methodological considerations 151
9.7 Conclusions 152
Chapter Ten: Discussion 154
10.1 Josephine's story 154
10.2 Life circumstances and barriers to employment experienced by DES participants with psychosocial disability 156
10.3 Enablers of work for DES participants with psychosocial disabilities 157
10.4 Mechanisms by which DES providers aim to address barriers to employment 158
10.5 Factors undermining the effectiveness of DES 160
10.6 Influence of the NPM-inspired reforms on the DES market 162
10.7 The influence of DES on the life circumstances of DES participants with psychosocial disability 167
10.8 Implications for DES policy and practice 169

10.9 Broader policy considerations 171
10.10 Strengths and limitations 174
10.11 Future research 175
10.12 Final conclusions 177
References 179
Appendix 1. Improving Disability Employment Study (IDES) survey 196
Appendix 2. IDES Participant capacity to consent checklist 231
Appendix 3. Interview guide for initial interview with job seekers 232
Appendix 4. Interview guide for follow up interviews with job seekers 235
Appendix 5. Project Distress Protocol 237
Appendix 6. Qualitative component Plain Language Statement 238
Appendix 7. Qualitative component Informed consent form 241

List of tables

Table 5.1	IDES survey domains and source of items	46
Table 5.2	Cronbach alpha scores for PWI and MHI-5	50
Table 5.3	Principle component analysis factor loadings for MHI-5 items for respondents with psychosocial disability, and, all other respondents combined.	50
Table 5.4	Principle component analysis factor loadings for PWI items for respondents with psychosocial disability, and, all other respondents combined.	51
Table 5.5	Participant Baseline demographics	59
Table 6.1	Participant demographics	68
Table 7.1	IDES survey respondent demographics	88
Table 7.2	Employment related difficulties and factors impacting on gaining and maintaining work for IDES respondents with psychosocial disability	91
Table 8.1	Baseline demographics	110
Table 9.1	Baseline demographics	135
Table 9.2	Employment status of qualitative interview participants at baseline and follow-up	137
Table 9.3	Supports IDES respondents' would like from DES workers	137
Table 9.4	Comparison of mental health (MHI-5) and well-being (PWI) between individuals with psychosocial disability versus any other disability type combined.	138
Table 9.5	Factors affecting well-being and mental health for IDES respondents with psychosocial disability.	139
Table 9.6	Considerations when choosing a DES provider	140

List of diagrams

Diagram 4.1	Szymanski and Hershenson's Ecological Model for Vocational Behaviour and Intervention for People with Disabilities	31
Diagram 4.2	The *CHIME Personal Recovery Model*	38
Diagram 9.1	Visualisation of narrative positions	135

Chapter One. Introduction

Chapter One introduces this thesis, which aims to explore the relationships between the life circumstances of people with psychosocial disability and their engagement with the Australian Disability Employment Services (DES) program. The chapter provides a brief overview of the context of the research, followed by a description of the aims and objectives of the study, alongside the mixed methods approach utilised. This is followed by an outline of the structure of the thesis.

1.1 Overview and context

Participation in work is regarded as central to an individual's social-economic status, civil and political participation, general health, and, mental health and well-being (Australian Human Rights Commission (AHRC), 2016; UN General Assembly, 2006). The right to work for people with disabilities is enshrined in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). Australia has committed to this right with its ratification of the UNCRPD. The consequential increased public policy focus on encouraging people with disabilities to gain and maintain work is further evidence of this commitment and recognition of the broad reaching benefits of employment. Indeed, at a population level, improving access to work for people with disabilities has the capacity to significantly contribute to health and well-being outcomes, and, the economy of individuals, families, and, the nation.

Yet Australians with disabilities continue to experience significantly poorer employment outcomes when compared to Australians without disabilities (Australian Bureau of Statistics (ABS), 2019). Among those with disabilities, people with psychosocial disability experience some of the lowest levels of employment (ABS, 2016). People with psychosocial disability often experience challenging life circumstances, including socio-economic inequalities, social exclusion, poor health outcomes, and multiple challenges in relation to access to health and welfare services (Morgan et al., 2012). These factors are both contributors to and consequences of their poorer employment outcomes. Many people with psychosocial disability also experience vocational (e.g. disrupted education and work histories) and non-vocational (e.g. discrimination, limited social networks) barriers to employment (Simonsen, Fabian, & Ethridge, 2013).

The Australian Disability Employment Services (DES) program, which sits within the broader social welfare system, is the federal government's specialised welfare program for people whose disability is assessed as their main barrier to employment (Department of Social Services (DSS), 2018a). DES providers function within a quasi-market of government contracted for-profit and non-profit

businesses who support and monitor the efforts of people with disabilities in receipt of income support (and a small number of voluntary participants) to actively promote their employability and participation in work. Of the more than 265,000 current DES participants, 40.7 per cent are reported to have a psychosocial disability as their primary condition (DSS, 2020).

Despite continual reform and significant investment, the DES program has been critiqued for not improving sustainable and meaningful employment outcomes (Department of Education, Employment and Workplace Relations (DEEWR), 2014; Nevile & Lohmann, 2011). The most recent reform, implemented on 1 July 2018, aims to increase competition and contestability[1] within the DES market. The reforms are intended to give DES participants more choice and control within a more contested market to determine which DES provider they use, and to change providers if they are not satisfied (DSS, 2016b). It is assumed that these reforms will incentivise DES providers to be more responsive to participants' needs, ultimately leading to improved employment outcomes

Better understanding of the lives and perspectives of DES participants with psychosocial disability, and how this influences their engagement with the DES program, is critical to ensuring those job seekers who experience particularly poor employment outcomes benefit from the reforms. This PhD study therefore aims to explore the relationships between the life circumstances of DES participants with psychosocial disability and their engagement with DES providers, in the context of the 2018 DES reforms.

1.2 The current thesis

The aim of this PhD study is to explore the relationships between the life circumstances of DES participants with psychosocial disability and their engagement with the federal government funded DES program. The specific research questions this PhD study aims to answer are:

1. What are the life circumstances of DES participants with psychosocial disability including i) demographic and socio-economic characteristics, ii) levels of health and well-being, and, iii) experiences of employment?

2. What are the vocational and non-vocational barriers and enablers to employment experienced by DES participants with psychosocial disability?

[1] Within the DES market, this refers to making it easier for new providers to enter and compete within the markets, alongside the removable of the previous market share of participants that was allocated to each DES provider, and, the removable of the need for participants to access a DES within a specified geographical boundary.

3. What are the most effective mechanisms by which DES providers can address vocational and non-vocational barriers to employment to help participants with psychosocial disability gain and maintain employment? What are the key enablers and barriers in this process?

4. Do DES participants with psychosocial disability perceive they have 'choice and control' in their engagement with DES providers? Is this changed with the 2018 DES reforms which aim to improve choice and control?

5. How do the life circumstances of DES participants with psychosocial disability change through their engagement with DES providers? Is this changed by the DES sector 2018 reforms?

1.3 Overview of methods

This study draws on mixed methods interpretivism and design, integrating both quantitative and qualitative methods of data collection, analysis and interpretation (Creswell, 2011; Howe, 2004). The PhD was embedded within the Australian Research Council (ARC) Linkage Project *Improving Disability Employment Study (IDES)*, which aims to improve understanding of factors that promote sustainable and meaningful employment outcomes for people with disabilities. The IDES project involves the implementation of a two-wave longitudinal quantitative study with individuals with disabilities engaged with government funded employment services, of which the first wave of data from 369 survey respondents was analysed as part of this PhD. The IDES survey includes items on disability, health and well-being, socio-economic conditions, and, engagement with employment services and work.

Alongside the IDES survey, I conducted qualitative interviews with 30 DES participants with psychosocial disability. Baseline and follow-up interviews were conducted with two cohorts of participants, the first recruited prior to the 2018 reforms, with the second cohort recruited post-reforms (with a total of 56 interviews conducted). Interviews focused on participants' life circumstances, and, how these circumstances influenced and were influenced by, their engagement with DES. Integrating the breadth of the quantitative data with the depth of the qualitative data has enabled the research questions to be more fully explored, as well as allowed for triangulation (Creswell, 2011; Doyle, Brady, & Byrne, 2009; Giddings & Grant, 2006; Halcomb, 2019).

1.4 Outline of thesis

Chapter One provides a brief overview of the thesis and context in which it is situated.

Chapter Two details the conceptualisation of psychosocial disability drawn upon throughout this thesis, alongside an overview of key factors influencing the experiences of Australians with psychosocial disability.

Chapter Three provides a brief history of the evolution of employment programs for people with disabilities within Australia's welfare system. The most recent DES reforms are then detailed in relation to previous research relevant to the DES program.

Chapter Four describes the two main conceptual models drawn upon throughout the research, Szymanski and Hershenson's *Ecological Model for Vocational Behaviour and Intervention for People with Disabilities,* and, the *CHIME Personal Recovery Model*.

Chapter Five details the research questions and mixed methods approach utilised in the study. This is followed by a description of the quantitative and qualitative methods and the analysis techniques used. A brief description of participant demographics are provided to introduce the results chapters.

Chapter Six is the first of the results chapters. It draws on the findings from the 30 baseline qualitative interviews conducted with DES participants with psychosocial disability, exploring their life circumstances, and, the vocational and non-vocational barriers and enablers to employment they experience. Constraints within and external to the DES system that make it more difficult for DES providers to address barriers to employment are also considered.

Chapter Seven presents an analysis of IDES Wave 1 quantitative survey data alongside that from the qualitative interviews, exploring how different policies intersect with contextual factors to further influence life circumstances of DES participants, and, the effectiveness of the DES program. The analysis focuses on the interaction between the National Disability Insurance Scheme (NDIS) and DES.

Chapter Eight explores how DES participants with psychosocial disability exercise choice and control to stay or change providers. It presents a narrative analysis of baseline and follow-up qualitative interviews with cohort one participants, describing the four narrative positions identified: 1) *Actively choosing to stay with their current provider;* 2) *Passively staying;* 3) *Reluctantly staying;* and, 4) *Tinkering on the edge of change.*

Chapter Nine presents a synthesis of IDES Wave 1 quantitative survey data exploring the mental health and well-being of IDES respondents with psychosocial disability, with, a narrative analysis of personal recovery in the context of DES which utilised data from the 56 qualitative interviews. Five narratives of personal recovery are presented: 1) *Recovery in spite of DES;* 2) *DES as a key actor in recovery;* 3) *DES playing a supporting role in fluctuating journeys of recovery;* 4) *Recovery undermined by DES*; and, 5) *Just surviving regardless of DES.*

Chapter Ten integrates the findings, contextualising the thesis with the broader literature. Policy and practice implications of the findings are described, followed by a reflection on the strengths and limitations of the study, future research opportunities, and, final conclusions.

1.5 Implications for policy and practice

Since the reforms in 2018, there has been a substantial increase in the number of people with psychosocial disability entering the DES system. Adoption of recovery-orientated approaches within DES policy and practice, has the potential to enhance the mental health and employment outcomes of this cohort, as well as support the reform objective of promoting choice and control within the context of DES. Achieving this requires investment in the upskilling of the DES workforce and greater support of mental health specialist providers within the market. The effectiveness of the DES program, however, will continue to be undermined, unless more can be done in the broader policy sphere to address the challenging life circumstances too often experienced by Australians with psychosocial disability.

Chapter summary

This chapter provided a brief overview of the context, aims and methods of this study. This was followed by an outline of this thesis. The following chapter describes the conceptualisation of psychosocial disability drawn upon throughout this thesis, alongside key factors influencing the experiences of Australians with psychosocial disability.

Chapter Two: Conceptualising psychosocial disability in the Australian context

Chapter Two details the conceptualisation of psychosocial disability guiding this research. It then discusses the key contextual factors influencing the life circumstances and access to employment for Australians with psychosocial disability. Disability and work related statistics are then described, highlighting the growing gap in access to employment experienced by people with disabilities when compared to people without disability.

2.1 Conceptualising psychosocial disability

Disability is conceptualised of within this thesis in accordance with the UNCRPD. The UNCRPD conceptualises people with disabilities as '*those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.*' (UN General Assembly, 2006, p. 4 Art. 1).

An impairment can be defined as a physical, intellectual, mental or sensory characteristic or condition, which may place limitations on an individual's personal or social functioning in comparison with someone who does not have that characteristic or condition. Disabling barriers experienced by people with impairment may include negative attitudes pertaining to impairment and/or disability; inaccessible environments; or, legislation and policies that do not promote or that prohibit equal participation by people with disabilities (Carroll et al., 2016; Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and CBM, 2012; Keogh & Down, 2014; UN General Assembly, 2006).

Psychosocial disability herein refers to disability that may arise from the lived experience of mental health conditions and/or mental illness. It is influenced by the interaction of a person's psychological condition, and, the socio-economic and cultural context in which they live (Drew et al., 2011; World Network of Users and Survivors of Psychiatry (WNUSP), 2008). Not all people who experience mental illness will identify with or experience psychosocial disability. The level of disability a person may experience will depend not only on their psychological functioning, but on the barriers and enablers they experience when trying to live and participate in their communities (Carroll et al., 2016; National Mental Health Consumer & Carer Forum (NMHCCF), 2011)

For people with psychosocial disability, barriers often stem from limited understanding of, or, the often negative attitudinal beliefs surrounding mental illness (Carroll et al., 2016; Drew et al., 2011). Societies and cultures have deep rooted 'social norms' against which a person's behaviours and characteristics are often measured, labelled and stereotyped (Link & Phelan, 2001). When a person is perceived to be behaving in a way that is outside the boundaries of a society's social norms or is seen as 'different', they are often relegated to an unconscious grouping of 'other', characterised by stigma. As a result of this stigma, a person may experience prejudice and discrimination, social distancing, loss of status, and, exclusion across important life domains (education, health, welfare, employment) (Carroll et al., 2016; Hatzenbuehler, Phelan, & Link, 2013; Link & Phelan, 2001; WNUSP, 2008).

2.2 Continuum of mental distress and psychosocial disability

Psychosocial disability can be further conceptualised as falling at the end of a continuum ranging from a state of minimal mental distress, through to mental health conditions and mental illness, and, psychosocial disability. Mental health conditions describe a broad range of features characteristic of a mental illness which may or may not be diagnosed (e.g. stress, anxiety, depression). An individual with a mental health condition may never meet the diagnostic criteria of a mental illness, whether they come into contact with a mental health service or not (Carroll et al., 2016; NMHCCF, 2011). Mental illness encompasses clinically diagnosed illnesses (e.g. depression, anxiety, schizophrenia, bipolar disorder) that significantly affect an individual's cognition (thinking), emotions (feelings), or social abilities (ways of behaving and interacting with others and the world around them) (Australian Institute of Health and Welfare, 2018; Council of Australian Governments (COAG), 2017; Lund et al., 2018). Mental illness is often episodic in nature, with fluctuations in the level of associated impairment and severity. However, as highlighted above, if a person with mental illness lives in a disabling environment, and, they do not have access to the services and supports they require, they may subsequently go on to experience psychosocial disability (Carroll et al., 2016).

Mental health and well-being on the other hand, are described as the ability to live and cope well despite the presence of stresses, problems and challenges, alongside the ability of individuals to realise their intellectual and emotional potential, and, make contributions to their communities (Canadian Mental Health Association (CMHA), 2015; COAG, 2017; Friedli & World Health Organization (WHO), 2009; WHO, 2003). Positive mental health and well-being is vital for the health and functioning of individuals and communities. Individuals who experience positive mental health

are more likely to lead healthier and more active lifestyles; attain higher levels of education; enjoy affirming relationships and social connectedness; and, benefit from productive engagement with employment (Friedli & WHO, 2009; Herrman, Saxena, & Moodie, 2005; Tugade, Fredrickson, & Feldman Barrett, 2004).

It is important to note that whilst mental health and mental illness are interrelated, they are in fact distinct constructs: people can experience mental health and well-being whilst living with a diagnosis of mental illness (CMHA, 2015; Cummins, Eckersley, Pallant, Van Vugt, & Misajon, 2003; Rumpf, Meyer, Hapke, & John, 2001; Slade, 2010). This is particularly so if people with mental illness and/or psychosocial disability live in supportive environments that recognise and value them as individuals, capable of attaining a satisfying and contributing life (Anthony, 1993). The notion of living well with or despite the presence of mental illness is epitomised in the *CHIME Personal Recovery Model*, as discussed further in section 4.2.

2.3 The rights of people with disabilities

The UNCRPD is the first human rights treaty to specifically define the rights of people with disabilities and outline State obligations to promote, protect and uphold these rights (Keogh & Down, 2014; UN General Assembly, 2006, p. 3). The UNCRPD has been described as the most significant platform of the disability rights movement, and, as making the attainment of human rights for people with disabilities more realisable than ever before in history (Harpur, 2012). Australia signed the UNCRPD on 30 March 2007, with ratification formalised on 17 July 2008 (United Nations Department of Economic and Social Affairs, 2019).

One of the defining features of the UNCRPD is that it provides guidance on what States need to do to operationalise rights based approaches, as well as providing a framework for holding States accountable (Harpur, 2012; Keogh & Down, 2014). Rights based approaches to disability recognise that people with disabilities have the same rights within a society as people without disability. Attaining these rights, however, requires the UNCRPD to be operationalised into effective policies (GIZ & CBM, 2012; Victorian Equal Opportunity and Human Rights Commission, 2008).

Within the Australian context, one of the key frameworks developed to ensure disability policy and programs align with our commitment to the UNCRPD, is the National Disability Strategy (NDS) 2010-2020. The aim of the NDS is to guide an integrated approach to address the barriers experienced by people with disabilities in participating in all aspects of mainstream society, including health care, education, housing, and, employment (COAG, 2011). Australia's Department of Social Services (DSS)

is currently leading negotiations to develop a new NDS for beyond 2020, recognising the need for a future NDS to enable greater coordination and collaboration between federal and state and territory systems, and, more inclusively and holistically promote the rights of all people with disabilities and their families (COAG, 2011; Productivity Commission, 2019b).

Whilst the rights outlined in the UNCRPD are in a way indivisible and inherently relevant to employment outcomes for people with psychosocial disability, the most pertinent Articles for this thesis are Article 3., and, Article 27. Article 3. of the UNCRPD highlights that individual autonomy is a fundamental requirement for people with disabilities to attain their human rights: *'Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons'* (UN General Assembly, 2006, p. 3). Indeed, extensive literature supports that choice and control in one's life promotes the well-being, social functioning, and, quality of life for people with and without disability (Eklund, 2007; Patterson et al., 2016; Shanks et al., 2013).

Since Australia's ratification of the UNCRPD, the national policy context has seen a growing emphasis on the choice and control of people with disabilities. This is perhaps most evident in the roll-out of the NDIS, commonly cited as the largest social policy reform implemented in Australia in nearly fifty years (Bonyhady, 2014). Administered by the National Disability Insurance Agency (NDIA), the NDIS aims to place people with disabilities at the centre of decision-making around what and how services and supports are purchased across their lifetime, through individualised budgets, to achieve self-determined goals (Bonyhady, 2014). The right to choice and control within the NDIS discourse, however, intertwines with that of neo-liberalism, which strongly values and promotes the role of consumer choice in the stimulation of markets, including the marketization of services made available to people with disabilities (Chesterman, 2015; Marston, Cowling, & Bielefeld, 2016; Purcal, Fisher, & Laragy, 2014). It is expected that 460,000 of the nearly four and a half million Australians with disabilities, will be eligible to receive NDIS support (ABS, 2019; Productivity Commission, 2017).

Article 27. outlines the States' obligations to *'recognize 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 by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to persons with disabilities.'* (UN General Assembly, 2006, p. 20). Attaining the right to work facilitates the attainment of other rights, such as health, independent living, and community participation (UN General Assembly, 2006). Yet, Australians with disabilities continue to experience multiple barriers to work and poorer employment outcomes when compared to Australians without disability as discussed further in section 2.7 below.

2.4 Social determinants of psychosocial disability

Mental health is more likely to be attained in environments that are protective and promoting of basic human rights, and, where individual capabilities are equitably nurtured across key life domains such as health, nutrition, education, environment, economic participation, social and cultural participation, and, safety and security (Friedli & WHO, 2009; Herrman et al., 2005; Lund et al., 2018). Conversely, increasing evidence highlights that mental health and human capabilities are compromised in environments of socio-economic deprivation which expose individuals to psycho-social distress and poor mental health: factors which in interaction with bio-psychosocial factors, may contribute to mental illness (Friedli & WHO, 2009; Herrman et al., 2005; Lund et al., 2018; Nussbaum, 2011).

In parallel to the social determinants of physical health, the mental health and mental illness of individuals and populations, are increasingly recognised to be shaped by structures, processes and experiences, within and across the social, economic and physical environments in which individuals are situated across their life course (Allen, Balfour, Bell, & Marmot, 2014; Fisher & Baum, 2010; Lund et al., 2018). The greater the level of socially determined inequality within populations, the proportionately higher the risk of poor mental health and mental illness across the population (Allen et al., 2014; WHO & Calouste Gulbenkian Foundation, 2014). People situated toward the lower end of the social gradient, may be at an increased risk of experiencing poorer mental health (Allen et al., 2014; Fisher & Baum, 2010; Lund et al., 2018; Silva, Loureiro, & Cardoso, 2016).

Poverty and lower economic status for example have consistently been found to be associated with an increased prevalence in common mental illnesses such as depression and anxiety in low, middle and high income countries (Lund et al., 2010; Lund et al., 2018). Unemployment is similarly recognised as an important factor associated with mental illness, as well as increasing the severity of mental illness and undermining the quality of life of people with mental illness (Lund et al., 2018; Slade & Longden, 2015). Certain groups, such as people with disabilities, are known to be more at risk of experiencing socially determined inequalities, including poverty and unemployment, at the detriment to their health and well-being (Kavanagh et al., 2016; Kavanagh et al., 2015; Milner, LaMontagne, Aitken, Bentley, & Kavanagh, 2014; Mithen, Aitken, Ziersch, & Kavanagh, 2015; WHO & World Bank, 2011).

Stigma associated with mental illness and disability has also been shown to be detrimental to health and well-being, with researchers evidencing stigma as a major source of stress that compounds

existing mental ill-health (Hatzenbuehler et al., 2013). Alongside this stress, stigma and discrimination often contribute to exclusion and barriers to participation across key life domains, such as exclusion from education, employment, and social participation in the community. Many of the barriers to education and employment experienced by people with disabilities for example can be linked to stigmatising attitudes, such as the low societal expectations of the capacity of people with disabilities (Carroll et al., 2016; Drew et al., 2011; Hatzenbuehler et al., 2013).

Indeed, Australians with disabilities continue to have poorer education levels compared to people without disability. In 2018, 33.4 per cent of people aged 15-64 with a disability had completed year 12 (the final year of secondary school), compared with 63 per cent of people without disability (ABS, 2016; ABS, 2019; AIHW, 2019c). Disrupted education and vocational training is a particular concern for people with psychosocial disability (Orygen Youth Health Research Centre, 2014; Simonsen et al., 2013). This is especially so given that the onset of mental illness most commonly occurs before the age of 25 years, coinciding with when most people access education. The episodic nature of symptoms can also make it difficult for young people to consistently engage with education. This is often compounded by barriers within the education system itself. Whilst there are a small number of specialist programs in Australia which support young people with mental illness to remain engaged with education, the reality for many young people is that there is limited support to help them stay in school (Orygen Youth Health Research Centre, 2014; Parletta, 2015). This not only limits educational attainments, but also reduces access to mainstream work experience opportunities, both important factors for developing self-efficacy for career development, and, increasing future access to employment (Simonsen et al., 2013).

In turn, exclusion from employment is a driver of the socio-economic disadvantage and subsequent health inequalities often experienced by many people with disabilities, particularly people with psychosocial disability, when compared to people without disability (Drew et al., 2011; Kavanagh et al., 2015; WHO, 2011). Recognition of the relationship between stigma, exclusion and social disadvantage has led to calls for stigma to be more formally recognised as a social determinant of health and health inequalities in and of itself (Hatzenbuehler et al., 2013).

2.5 Prevalence and health implications of mental illness and psychosocial disability

The ABS National Survey of Mental Health and Well-being, conducted in 2007, provides the most comprehensive estimates of the prevalence of mental illness in the Australian adult population. It estimates that more than 3.6 million people aged 16-85 years or approximately 20 per cent of the

adult population experience mental illness each year (ABS, 2008). Of this, 3 million people are thought to have a mild to moderate condition, 625 000 are thought to have a severe episodic or severe and persistent illness, with 65 000 reported to have a severe and persistent disabling condition (ABS, 2008). It is further estimated that 45 per cent of Australians will experience a mental illness at some point in their lifetime, of which less than half will access services (ABS, 2008; Cook, 2019). The more recent ABS National Health Survey estimated 4.8 million Australians (20.1%) live with a mental or behavioural condition, an increase of 2.6 per cent from the 2014-15 survey (ABS, 2018; Cook, 2019).

Of particular public health concern for people with mental illness and psychosocial disability, is the limited support available to address issues related to impairment, poorer physical health and the co-occurrence of other health conditions (NMHCCF, 2011). Compared to the general population, people with mental illness and psychosocial disability experience poorer physical health outcomes, such as higher rates of diabetes, metabolic disorders, and heart disease. Health outcomes are further influenced by factors such as the side-effects of medication, the higher incidence of drug and alcohol misuse, and, financial hardship (Morgan et al., 2012; NMHCCF, 2011). Australians with mental illness have further been shown to have a reduced life expectancy of up to 15 years for women and 20 years for men (Lawrence, Hancock, & Kisely, 2013; Thornicroft, 2013).

Barriers in addressing issues related to co-occurring health conditions have been attributed to insufficient availability of services, as well as limited capacity of general health and disability services to recognise and address the health needs of people with psychosocial disability. When these health needs are not met, mental health conditions are often exacerbated, compounding barriers to employment (Bird et al., 2014; NMHCCF, 2011; Simonsen et al., 2013).

2.6 Costs and resourcing of mental health systems

The AIHW estimates mental illness accounts for 12.1 per cent of the country's burden of disease, slightly lower than cancer (19%) and cardiovascular diseases (15%) (AIHW, 2016). The cost of mental illness in Australia has been estimated to be between $41 billion to $60 billion per year, with an additional $130 billion in costs associated with the diminished health and reduced life expectancy of individuals. The Australian federal government estimates its health spending for the 2019/2020 budget will be approximately $89 billion for the 2019/2020, with state's such as Victoria estimated to spend approximately $20 billion on health (Australian Government, 2019; State of Victoria, 2019a). Yet Australia's mental health system receives just under $10 billion per year to respond to

the high prevalence of mental illness within the population, with approximately 33.9 per cent provided by the federal government, 60 per cent provided by state and territory governments, and, 5.5 per cent provided by private health insurance funds (AIHW, 2018, 2019a).

The resourcing of mental health systems in Australia has been widely criticised as grossly inadequate, and, inappropriately concentrated within acute emergency services at the expense of community mental health services (COAG, 2017; Productivity Commission, 2019a; State of Victoria, 2019b). Subsequently, the growing number of Australians experiencing mental illness, often have to reach crisis point before they can access services that are not resourced to meet their long term needs. Not only is this harmful to the health and well-being of individuals, but negatively impacts on the mental health workforce due to staff shortage and not being able to adequately respond to the needs of individuals, and, the broader population who have family, friends and/or employees experiencing mental health challenges (Productivity Commission, 2019a; State of Victoria, 2019b).

Australia's Fifth National Mental Health and Suicide Prevention Plan recognises the need to increase the resourcing and integration across all levels of the mental health system, to ensure that they are better tailored to the both the mental and physical health needs of individuals (COAG, 2017). The plan also emphasises the need to improve coordination between health and other social service organisations. As an example, there is a strong association between mental illness, disability and housing insecurity in the Australian context. It is difficult to holistically address mental illness and disability without also addressing issues such as the higher levels of housing insecurity experienced by these cohorts (Aitken et al., 2019; AIHW, 2019d; Brackertz, Davidson, & Wilkinson, 2019; Jacobs, Hulse, Stone, & Wiesel, 2016). Improving coordination between mental health and social services, however, is often hindered by the complexity of how these programs are governed and funded across multiple levels and areas of government (Olney, 2016; Productivity Commission, 2019a).

The mental health landscape has been further complicated and disrupted as several federal, and state and territory funded mental health programs transition across to the NDIS (AIHW, 2018; Crowther & Collister, 2014; Joint Standing Committee on the NDIS, 2017). Despite the federal government introducing funding to support the continuity of programs during this transition, there has been significant uncertainty and arising gaps in responsibility and funding, not only for mental health programs, but for other critical components of the broader social support system such as housing, health, and, welfare. This is of particular concern for people with psychosocial disability, as this cohort is recognised as experiencing extreme difficulties in accessing and benefitting from the NDIS, which is occurring alongside a reduction in the availability of services and supports both within

and external to the NDIS (Joint Standing Committee on the NDIS, 2017; Smith-Merry, Buchanan, Yen, & Drinkwater, 2019). The combination of these factors negatively influences mental health, and, compounds existing barriers to employment.

2.7 Disability and work

> *'Intrinsically, the value of work is found in its central role as one important aspect of a person's psychological well-being. The intrinsic value of work is the value an individual finds in performing the work, in and of itself, outside of its utilitarian function. Instrumentally, the value of work is found in its identity-defining characteristic; its basis for providing the necessities of life; its role in giving meaning and structure to the adulthood years; and serving as a channel for the individual's talents, abilities, and knowledge.'* (Quick, Murphy, Hurrell Jr, & Orman, 1992, p. 4)

Participation in work has long been argued as fundamental to an individual's social-economic status, civil and political participation, and, health and well-being (Blustein, 2008; Jahoda, 1982; Modini et al., 2016; Saleh & Bruyère, 2018; Szymanski, Enright, & Hershenson, 2012; Waddell & Burton, 2006). The benefits of work extend to people with and without disability. Indeed, research has shown employed people with disabilities experience greater mental health benefits as a result of workforce participation, when compared to employed people without disability, and, unemployed people with disabilities (Milner et al., 2014). There are also economic arguments for improving employment outcomes for people with disabilities. Economic modelling has shown that improving the labour force participation rate of Australians' with disabilities by one third, would contribute $43 billion dollars to Australia's Gross Domestic Product over a decade (COAG, 2017; Deloitte Access Economics, 2011).

By contrast, unemployment can lead to social exclusion, economic disadvantage, poor mental and physical health, exacerbation of mental illness, and, housing instability, all with resultant costs to individuals, families and communities (Bush, Drake, Xie, McHugo, & Haslett, 2009; Jahoda, 1982; Mueser, Drake, & Bond, 2016; Simonsen et al., 2013; Strauser, 2013). This is of particular concern for Australian with disabilities, who continue to experience poorer employment outcomes, compounding existing socio-economic disparities when compared to Australians without disability (ABS, 2016, 2019; Kavanagh et al., 2016; Milner et al., 2014).

The 2018 ABS Survey of Disability, Aging and Carers (SDAC) highlighted that of the 4.4 million Australians with disabilities (17.7% of total population), 2.1 million are of working age (15 – 64 years). Just over half of this working age population (53.4%) are in the labour force (looking for or in paid employment for at least one hour a week) (ABS, 2019). These data remain in line with the 2015 SDAC findings, suggesting efforts to increase labour force participation for people with disabilities over this period have been ineffective. They also demonstrate a widening gap in employment outcomes when compared to people without disability, who have experienced a rise in labour force participation from 83.2 per cent in 2015, to, 84.1 per cent in 2018 (ABS, 2016, 2019).

Just under half (47.8%) of the working aged population with disabilities are employed (employed for at least one hour per week, sustained from 48% in 2015), compared with 80.3 per cent of people without disability (up from 79% in 2015). In terms of full-time employment, 28.3 per cent of people with disabilities of working age are employed full time, compared to 54.8 per cent of people without disability. There has however been an increase in the number of people with a profound or severe disability who are working full-time from 7.9 per cent in 2015 to 11.4 per cent in 2018 (ABS, 2016, 2019).

Whilst there has been a decrease in the unemployment rate of people without disability (5.3% in 2015 to 4.6% in 2018), the unemployment rate for people with disabilities has remained at 10.3 per cent over this time frame, increasing from 8 per cent in 2003. People with disabilities are also more likely to report being underemployed (people employed for a few hours per week, but who want and need more hours) to people without disability (11% compared to 8%) (ABS, 2016; ABS, 2019; AIHW, 2017). These gaps in employment outcomes have persisted for more than 20 years, with Australia reported as one of the lowest performing Organisation for Economic Co-operation Development (OECD) countries in relation to employment outcomes for people with disabilities (OECD, 2009).

Among people with disabilities, the 2015 ABS SDAC highlights that people with psychosocial disability have the lowest labour force participation rate (29%) and the highest unemployment rate (19%)[2] (ABS, 2016; DSS, 2016b). Australia's second national Survey of High Impact Psychosis (SHIP) conducted in 2010 with 1,825 people with psychosis found only 21.5 per cent were in paid employment in the week prior to survey participation, and, only 32.7 per cent had undertaken any work in the previous 12 months (Morgan et al., 2012). This pattern persists despite evidence

[2] Noting this level of disaggregation is not yet available for the 2018 SDAC.

highlighting that the majority of people with psychosocial disability would like to work and have the capacity to do so with the right support. It also underscores the need for a well-functioning DES program that can effectively understand and respond to the vocational and non-vocational barriers of participants with psychosocial disability (Drake & Whitley, 2014; Provencher, Gregg, Mead, & Mueser, 2002; Slade et al., 2014).

Chapter summary

Chapter Two described the conceptualisation of psychosocial disability grounding this thesis, and the key contextual factors influencing the life circumstances and access to employment for Australians with psychosocial disability. Employment statistics highlighted the urgent need to improve access to work, particularly for Australians with psychosocial disability. This requires the support of an effective DES program, in collaboration with broader social policies and programs. The next chapter provides an overview of the evolution of the DES program within the context of Australia's welfare system, going onto describe the most recent DES reform implemented on 1 July 2018.

Chapter Three: Reforming Australia's Disability Employment Services

Australia's social security system was founded with a strong focus on maximising economic and social participation, whilst protecting the right to security for those most in need (Ey, 2012; Herscovitch & Stanton, 2008). Chapter Three outlines the evolution of the DES program within the broader context of Australia's social security system. It goes on to describe key issues influencing the effectiveness of the DES program, culminating in the current DES reforms in which this research is situated.

3.1 The evolution of the Disability Employment Services program

The Australian federal government first implemented a vocational training program for veterans with disabilities returning from the First World War (Goggin & Newell, 2005). Recognition of the need to expand this to non-veterans culminated in legislation in 1941 to implement the Vocational Training Scheme for Invalid Pensioners. This scheme was consolidated with vocational training for veterans in 1948 under the Commonwealth Rehabilitation Scheme (Goggin & Newell, 2005). Increasing unemployment in the 1970s, contributed to the growing concern around the rights of Australians with disabilities, particularly in relation to work and discrimination (within and external to the labour market) (Goggin & Newell, 2005; Handicapped Programs Review, 1985). These issues were publicly highlighted in the 1983-85 Handicapped Programs Review (New Directions Report) which, alongside the Kirby Inquiry into Labour Markets in 1985, called for major disability reform to address the significant issue of limited employment options for people with disabilities, and, a shift of government funding from employment programs that directed people with disabilities into the often inadequate sheltered workshop environment (Handicapped Programs Review, 1985; Kirby, 1985). The New Directions Report further advocated for the choices of people with disabilities to be recognised and supported, and, for legislation of the rights of people with disabilities to be adopted (Handicapped Programs Review, 1985).

The subsequent Disability Services Act 1986 was enacted in 1987, enabling major reform to the disability services system. Alongside the continuation of the government funded and implemented Commonwealth Rehabilitation Service (with the name changing to CRS Australia in 1988), these reforms included the introduction of two types of provider contracted employment services for people with disabilities, implemented under the Commonwealth's Disability Services Program: 1) Competitive Employment, Training and Placement (CETP); and, 2) Supported Employment Services.

The Disability Services Act 1986 was amended in 1993 to allow for the introduction of the Disability Services Standards to help regulate providers operating under the Disability Services Program (DEEWR, 2014). In the mid-1990s the Baume Review further evaluated employment support delivered under the Disability Services Program, with the 1995 budget response and policy discourse demonstrative of the shift towards defining the Disability Services Program as a Labour Market, and, leading to the subsequent development of a performance-based funding framework for employment services (Baume & Kay, 1995; Department of Education Employment and Workplace Relations, 2014).

Following a trial in 1999 to 2002, the government introduced Case Based Funding under the newly introduced Disability Open Employment Services and Business Services program, formally replacing block funding of government contracted employment services in 2005. Alongside the introduction of new service contracts in 2006, the Disability Open Employment Services program changed to the Disability Employment Network (DEN), whilst CRS Australia continued to deliver rehabilitation services under the Vocational Rehabilitation Services program (VRS). The VRS program was opened up to the market in 2007, with CRS Australia retaining two-thirds of the government contracted funding (DEEWR, 2014).

The Disability Employment Services (DES) program replaced DEN and VRS in 2010, alongside a review of National Standards for Disability Services which commenced in April 2010. The DES program was further evaluated in 2013 before being extended through to 2015, and then again through to 1 July 2018, when the newly reformed and current DES program was introduced (DEEWR, 2014; DSS, 2015c).

3.2 Current federal government employment services

There are three main streams of employment services currently supported by the Australian Government:

> **1) Australian Disability Enterprises (ADEs):** ADEs are commercial businesses (e.g. plant nurseries, recycling, packaging) operated by mostly not-for-profit organisations across Australia, which provide employment opportunities for approximately 20,000 people with moderate to severe disability in a supported environment. ADEs receive financial support from the Department of Social Services (DSS, 2015c).

2) *jobactive*: is the mainstream employment program through which a network of providers (mix of profit and not-for-profit) are funded to improve employment outcomes of individuals in receipt of unemployment benefits (referred to within Australia's social security/welfare system and herein as income support), who have been assessed by Centrelink[3] as able to work at least eight hours a week, and, for whom disability is *not* assessed as their main barrier to employment. Income support recipients for whom disability is assessed as their main barrier to work, are referred into the DES program. If a person is assessed as not able to work for eight hours a week, they may be advised to try and engage with an ADE, or, apply for the Disability Support Pension (DSP) (DEEWR, 2014; DSS, 2017a).

Centrelink's process for referring income support recipients into either *jobactive* or DES, has been criticised as under-identifying the mental illness and disability related barriers to employment often experienced by participants. This is reported to result in people with mental illness and psychosocial disability streamed into *jobactive* rather than DES, and subsequently receiving a lower level of support than they actually require (Olney, 2016; Perkins, 2011).

Of the total December 2019 *jobactive* caseload of 613, 371 people, 29.0 per cent (178, 031) are reported to have a disability. This represents an increase from the 27.0 per cent (193, 159 of 714, 463) of *jobactive* participants with a disability in September 2017 (Department of Employment Skills Small and Family Business, 2019). The overwhelming majority of *jobactive* participants receive income support, such as the Newstart Allowance[4], and have mutual obligation requirements that they must comply with in order to remain in receipt of income support.

3) the DES program: is the specialised employment services program for income support recipients (and a smaller number of DSP compulsorily engaged participants, and, voluntary participants) whose disability, injury or health conditions are assessed by Centrelink as their main barrier to gaining and maintaining employment (DEEWR, 2014; DSS, 2017a). DES operates across two streams:

[3] Centrelink was established in 1997 as the main gateway to income support/social security assistance and employment related services.
[4] The Newstart Allowance is the main income support payment for Australians who are unemployed. To receive the payment, individuals must be over the age of 22 but under the age set for the aged pension, looking for work, under the income and assets test level, and, prepared to meet mutual obligation requirements.

i) Disability Employment Services - Disability Management Services (DES-DMS), for people with disabilities, injury or health conditions who might occasionally need support to gain and maintain employment.

ii) Disability Employment Services- Employment Support Service (DES-ESS), for people with permanent disability who will require long-term and a higher level of support to gain and maintain employment (DSS, 2015c, 2018a).

The DSS contract DES providers (also a mix of not-for-profit and for-profit providers) to support DES participants across three to four main phases. These phases are combined to make up a 'Period of Service':

i) Employment Assistance – which lasts up to 18 months. This includes services and supports provided by DES providers to participants to support job readiness and applying for work.

ii) Extended Employment Assistance – which lasts up to six months (if a person is assessed as requiring further employment assistance after 18 months of assistance).

iii) Post Placement Support – which is support provided by DES providers to participants to help them maintain gained employment, while they progress towards an Employment Outcome. Employment Outcomes include 'four week outcomes' (i.e. a participant remains in employment, or apprenticeship/traineeship, or other form of education for four weeks after commencement in employment or education), 13 week outcomes, 26 week outcomes, and, the 52 week outcome introduced during the most recent reform. DES providers receive outcome payments when participants reach these outcomes.

iv) Ongoing Support – support provided if a participants is assessed as requiring a greater level of post placement support and is tracking towards a 52-week Outcome (DSS, 2018a).

As of January 2020, there were approximately 276,000 participants currently engaged with the DES program, 41.2 per cent of whom are reported to have a 'psychiatric'[5] disability as their primary condition (DSS, 2020). This compares to figures generated just prior to the 1 July 2018 DES reforms,

[5] DSS use the terminology 'psychiatric' disability to refer to people whose disability is associated with a mental health condition or mental illness.

when approximately 187,000 participants were engaged with DES, of whom 38.8 per cent were reported to have a 'psychiatric' disability as their primary condition. The increase includes a rise in both the number of mutually obligated and voluntary participants (DSS, 2020). DSP recipients under the age of 35 years who are assessed as able to work 8 hours or more, are compulsory required to access DES, albeit with fewer mutual obligation requirements than Newstart Allowance recipients. DSP recipients over the age of 35 years who are assessed as able to work 8 hours or more per week, are able to voluntarily access DES. People who are not on income support or the DSP but are assessed as able to work eight hours a week and have a disability, are also able to voluntarily access DES (DSS, 2018a).

3.3 Calls for reform

In response to ongoing concerns regarding the nation's stagnant employment outcomes for people with disabilities, the Australian Government established a National Disability Employment Taskforce in April 2015, to conduct a review of the disability employment system and inform the development of a new National Disability Employment Framework (DSS, 2015b, 2015c). Consultations held across Australia highlighted key issues contributing to the persistently poor employment outcomes for people with disabilities (DSS, 2015a). These included a lack of awareness of government programs available to support employers to employ people with disabilities, and, support people with disabilities to gain and maintain employment, alongside a lack of understanding and focus on the needs of the employers within government funded employment services. Significant community and workplace discrimination experienced by people with disabilities was again highlighted as a key barrier to improving employment (AFDO, 2014; AHRC, 2016; DSS, 2015a; Nevile, 2016)

Specifically relevant to DES, was the ongoing push for more individualised approaches to supporting people with disabilities, particularly within their engagement with employment services. This included the recommendation to increase participant choice and control in how people with disabilities access employment services and the type of support they require. This aligns with research calling for more holistic and coordinated approaches to service provision which work across people's lives and support career development, aspirations and progression. Also recognised, was the challenges experienced by employment services in addressing the complexity of vocational and non-vocational barriers to employment often experienced by participants (AFDO, 2014; McDowell, 2018; Nevile, 2016; Nevile & Lohmann, 2011; Olney, 2016).

The perspectives of people with disabilities engaged with the DES program are more limited in the literature and consultation documentation but, where available, highlight a need for more

individualised services which better respect their circumstances and work aspirations (AFDO, 2014; Nevile & Lohmann, 2011; Stafford, Marston, Chamorro-Koc, Beatson, & Drennan, 2017). Indeed, the complex and intersecting nature of these barriers as experienced by people with psychosocial disabilities in particular, and the limited resources made available to DES to address these complex barriers, has been previously cited as an underlying reason why DES participants with psychosocial disability seem to fare less well compared to other participants.

An evaluation of the DES program conducted in 2013 analysed employment outcomes for DES participants between March and December 2010. Of the 7000 job seekers with 'psychiatric disability', approximately 25 per cent were placed in a job, with less than 14 percent reaching the 13 week outcome. This was compared to the overall performance of DES participants at that time, with 40 per cent of participants reported as being placed in a job, and, 38 per cent reaching the 13 week outcome (DEEWR, 2014).

Current available DES data are difficult to interpret due to different methods and timeframes used across the data sets and reports. However, whilst it appears that employment outcomes continue to fluctuate in a similar trend as observed prior to the reforms, it does appear that participants with psychosocial disability may now have employment outcomes more comparable to participants with other types of impairment (DSS, 2020).

Nonetheless, concerns remain that the DES program does not enable the implementation of approaches recognised internationally as best-practice to support people with psychosocial disability gain and maintain employment. This includes the practice of Supported Employment or Individual Placement and Support (IPS), which is implemented widely across the USA (Lockett, Waghorn, & Kydd, 2018; Parletta, 2015; Sherring, Robson, Morris, Frost, & Tirupati, 2010; Suijkerbuijk et al., 2017; Waghorn, Collister, Killackey, & Sherring, 2007; Waghorn, Dias, Gladman, Harris, & Saha, 2014; Waghorn & Hielscher, 2015).

IPS incorporates eight core principles: 1) eligibility based on client choice; 2) focus on competitive employment; 3) integration of mental health and employment services; 4) attention to client preferences; 5) work incentives planning; 6) rapid job search; 7) systematic job development, and, 8) individualised job supports. Evidence suggests that for IPS to be effective, high fidelity with all eight principles is required (R. King et al., 2006; Mueser et al., 2016; Noel et al., 2017; Parletta, 2015; Waghorn et al., 2007).

Challenges in the Australian context include the difficulty of implementing key criteria of the IPS model, such as integration of mental health and employment services, when these services function

under separate funding and contractual arrangements with different levels and branches of government, with often competing priorities and key performance indicators; the funding model of the current DES program creates financial disincentives for providers in providing more individualised support to participants because this would require smaller case numbers per employment consultant and perceived risk of reduced revenue; and, the limited availability of workers who have the expertise to implement IPS based approaches (R. King et al., 2006; Morris, Waghorn, Robson, Moore, & Edwards, 2014; Olney, 2016; Parletta, 2015; Waghorn et al., 2007; Waghorn & Hielscher, 2015).

Despite this, a growing number of Australian mental health services, often in collaboration with but not led by employment services, are trialling and evaluating different models of IPS (Chang, Douglas, Scanlan, & Still, 2016; Dawson & Muller, 2019; Parletta, 2015; Sherring et al., 2010; Western Australian Association for Mental Health, 2019). Indeed, as part of their focus on addressing the high youth unemployment rate, the DSS are also currently implementing an IPS trial in collaboration with the youth mental health focused *headspace* organisation. The trial focuses on improving educational and employment outcomes of young people with mental illness aged up to 25 (DSS, 2016a).

However, much of the research on how IPS may be implemented in the Australian context does not take into sufficient consideration factors external to DES that undermine access to work for people with psychosocial disability. Some commentators, such as Mellifont (2017) recognise this issue, and, alongside advocating for a reformed DES system that does enable implementation of IPS, calls for the need to understand broader contextual factors which may hinder the effectiveness and implementation of DES reforms and evidence-based practice within the system (Mellifont, 2017).

3.4 The latest DES reform and the ongoing influence of New Public Management

Despite the initial broad focus on how to reform the disability employment system, the subsequent Disability Employment Reform 2018 Industry Information Paper focused specifically on fairly modest proposed changes to DES, supported by a significant increase in investment in the program with over $3 billion earmarked in the 2017-2018 federal budget to support implementation of the latest DES reform (DSS, 2017b).[6]

[6] The 2016-2017 DES budget was approximately $832,768 million. Increasing in 2017-2018 to $886,309 million, $854,811 million in 2018-2019; $853,533 million in 2019-2020; and $877,477 million in 2020-2021.

The current and previous DES program reforms follow a trend across many OECD governments, to outsource public services through mechanisms frequently referred to under the banner of New Public Management (NPM) (Hood, 1991, 1995; Olney, 2016). This trend is premised on a key assumption of NPM - that marketization of the private sector to deliver public services is more effective, efficient and responsive to the needs and choices of users, compared to state delivered services (Considine, O'Sullivan, & Nguyen, 2014; O'Brien & Dempsey, 2004).

As such, the NPM inspired ongoing reforms to DES have seen its transition over the years from a publicly funded and delivered service, to a mix of state and non-state block funded services, to the current quasi-market of for-profit and non-profit businesses funded to support and monitor the efforts of people with disabilities in receipt of income support (and a small number of voluntary participants) to actively promote their employability and participation in the labour market (Considine, Nguyen, & O'Sullivan, 2018; DSS, 2016b; Lantz & Marston, 2012; McDonald & Marston, 2008; Nevile & Lohmann, 2011).

NPM theories emphasise the role of consumer choice in driving market changes and efficiency. Indeed, key changes proposed and subsequently implemented on 1 July 2018 are intended to increased choice and control for participants in how they are referred to DES providers. Prior to the reform, Centrelink referred a market share of participants to each DES provider, with referrals restricting participants to specified geographical boundaries. As such, DES providers were guaranteed an ongoing stream of participants and income. Post-reforms, whilst Centrelink are still able to refer participants to a particular DES, participants are also able to choose which DES they access and are no longer restricted by geographical boundaries.

Alongside allowing more DES providers into the market, DSS hope these changes will increase competition between providers and contestability within the DES market. Participants are now more readily able to change providers if they are not satisfied, and, afforded some flexibility in how meetings between themselves and DES providers are conducted as part of mutual obligation requirements (DSS, 2017a, 2018a). Overall, these changes assume that: a) participants will exercise choice and control in relation to their DES provider; b) this will incentivise providers to be more efficient and responsive to participants' needs as providers compete; ultimately leading to c) improved employment outcomes (DSS, 2017a).

These NPM inspired changes assume that choices are made in isolation, with limited consideration of the complex needs and circumstances often experienced by individuals that influence decision-

making capabilities (Clarke, Smith, & Vidler, 2005; Glendinning, 2008). Decision-making processes, however, have been shown to be influenced by numerous factors. These include psychosocial functioning, age, availability of support and resources, and that these characteristics interact with broader social issues such as socio-economic disadvantage, housing, unemployment and experiences of discrimination to influence whether and how people make decisions (Burchardt, Evans, & Holder, 2015; Knight et al., 2018). Indeed, alongside the increasing number of DES participants with psychosocial disability, there has been an increasing proportion of participants reported to be experiencing homelessness; with 'ex-offender' status; and, increasing numbers of participants reported to come from a refugee background (DSS, 2020). Such interactions of complexities, similarly influence people's desire, willingness and capability to exercise choice and control within quasi-markets when this is extended to them under NPM inspired policy reforms to programs such as DES (Crozier & Muenchberger, 2013; Glendinning, 2008).

The DES reforms present challenges for providers too. As has been seen in the mainstream *jobactive* employment program, not all providers can financially sustain themselves through such change (Glendinning, 2008; McDonald & Marston, 2008). At the commencement of the 2010 DES contract, there were 224 DES providers contracted to deliver services. Just prior to the 2018 reforms, DSS contracted approximately 119 DES providers (DSS, 2020). This rose to 138 providers at introduction of the new July 2018 contracts. Yet the number of DES providers has again fallen, and as of January 2020, were sitting at 117 providers (DSS, 2020).

The latest reforms are also aimed at eliminating perverse incentives for DES provider risk selection behaviours. Often referred to as 'creaming and parking', risk selection occurs when providers focus their attention on participants deemed easier to place in a job in order to maximise financial returns, while providing a minimal service to others perceived to be less likely to achieve employment outcomes (Nevile & Lohmann, 2011). To try and address this, a new 'risk adjusted funding model' was introduced in recognition that some participants require more support than others to gain and maintain employment. DES funding for Service and Outcome fees changed from a split of 60:40 to a 50:50 split. Outcome payments were also changed from occurring at job placement, 13 and 26 weeks, to being made for a job placement lasting 4 weeks, 13, 26 and 52 consecutive weeks. Along with indexed funding for providers, it is hoped this will incentivise DES providers to improve support of participants to gain and maintain more sustainable employment (DSS, 2017a).

3.5 Increasing emphasis on 'activation' within Australia's social security system

Alongside the afore mentioned NPM-inspired reform to employment services, Australia has also seen an increasing emphasis on the 'activation' of its welfare recipients (Considine et al., 2014; Howard, 2012). The emerging high levels of unemployment in the 1970s saw substantial increases in the number of individuals in receipt of unemployment social security payments (first introduced in 1945), and, the DSP (which evolved from the first Invalid Pension for people with disabilities introduced in 1910) (Ey, 2012; Herscovitch & Stanton, 2008; Ziguras, 2014). These circumstances have led successive governments to continually reform the social security system, in an attempt to limit the number of welfare recipients and associated spending (Daniels, 2010; Ey, 2012; Herscovitch & Stanton, 2008; Ziguras, 2014).

Initiated in the late 1980s, 'activation' policies originally targeted young unemployed welfare recipients, obligating them to participate in job readiness and/or subsidised employment programs (Cass, 1988). Under the banner of what continues to be referred to as 'Welfare to Work' reform, mutual obligation requirements were formalised in 1997, with the reach of 'activation' expanding to include most unemployed people, including people with disabilities. During this time, Centrelink was established as the gateway to income support and employment related services, and, given the responsibility for assessing the job capacity of income support recipients, as well as the barriers they may experience (DEEWR, 2014).

'Welfare to Work' reforms parallel the Australian government's agenda to increase the workforce participation and reduce the welfare dependency of people with disabilities, including through policy measures aimed at tightening the eligibility criteria of the DSP (Marston et al., 2016; McClure, Sinclair, & Aird, 2015). This has had the effect of moving more people with disabilities onto income support payments with greater mutual obligation requirements, such as the Newstart Allowance (DSS, 2019d; Li, Brown, H.N, Miranti, & Vidyattama, 2019; Parliament of Australia, 2018). Whilst people with disabilities on Newstart often have fewer mutual obligation requirements compared to recipients without disabilities, the rate of payment of Newstart benefits is significant lower than the DSP.[7]

[7] Partial capacity to work refers to Newstart recipients who have a physical, intellectual or psychiatric impairment, which would prevent them from working 30 hours per week. The proportion of people receiving Newstart who have partial capacity to work, has increased from 25.6% in 2014 (180,656 of 705,814) to 42% in 2019 (289,489 of 686,785). The current rate of the DSP is $850 AUD, with the current rate of Newstart is $559 AUD for singles with no dependents, and, $604 AUD for singles with dependents or for people who are single and aged over 60, or who have been on the payment for 9 continuous months.

Ongoing concern has been raised over the payment level of Newstart, which has not seen a real rise in the rate of payment in line with national living standards since 1994. This is in contrast to the increases observed within the Aged Pension and Disability Support Pension over a similar timeframe (Deloitte Access Economics, 2018; DSS, 2013; Li et al., 2019; McClure et al., 2015; Parliament of Australia, 2018). The financial hardship experienced by Newstart recipients has been associated with a widening gap in health and living standards when compared to average Australians. These gaps further increase for recipients with disabilities, who often have greater living costs associated with disability (Anglicare Australia, 2019; Collie, Sheehan, & McAllister, 2019; Deloitte Access Economics, 2018; Li et al., 2019).

Compounding financial hardship and the ever-increasing conditionality placed on Newstart recipients, is the recent introduction of the Targeted Compliance Framework within both the *jobactive* and DES programs (Australian Government, 2018). As such, individuals can lose their income support if their employment service provider or employer deem them '*persistently and wilfully non-compliant'* in their engagement with employment programs and work, reinforcing the government's position that *'Income Support Payments for unemployed people should only be available to those who are genuine in their efforts to move into paid work'* (Australian Government, 2018, p. 3; Parliament of Australia, 2017), regardless of disability.

Such measures have been argued to further shift the discourse from supporting the right to assistance from the State, to 'responsible citizenship' whereby welfare support has to be earned, and whereby paid employment is valued over other types of contribution, such as the role of caring or volunteering (Maker, 2017; Marston et al., 2016; Nevile, 2012). Within this discourse, individuals are increasingly held personally responsible for their unemployment, and therefore obligated to actively engage in employment programs to change behaviour, promote their employability, and, ultimately reduce the burden on contributing members of societies (i.e. tax payers) (Ey, 2012; Lantz & Marston, 2012; Marston et al., 2016; Olney, 2016).

Despite this ever-increasing conditionality placed on welfare recipients, there continues to be high rates of unemployment, particularly for job seekers with disabilities. Researchers argue this is because punitive measures do not address the broader structural barriers to employment, such as discrimination, and, the limited number of jobs that meet the diverse skills, aspirations and needs of people with disabilities (Nevile, 2012, 2016; Slade & Longden, 2015). As such, job seekers are subjected to increasing measures of compliance and demoralising rhetoric regarding 'welfare dependency', while broader barriers and negative employment outcomes remain. The combination

of these factors, alongside the negative experiences people often face within compliance driven employment programs, has been shown to contribute to poor self-worth, and, disengagement with employment services (Beck, 2018; O'Halloran, Farnworth, & Thomacos, 2019). Furthermore, some academics assert that the negative 'welfare dependency' political discourse has led to the increasingly negative employer and community attitudes towards the long-term unemployed, compounding attitudinal barriers to employment (Schofield & Butterworth, 2018; Slade & Longden, 2015).

Chapter summary

Chapter Three discussed the evolution of Australia's DES program, culminating in the most recent reforms. The chapter highlighted the concern that continual DES program reform has not shifted employment outcomes, particularly for people with psychosocial disability. Challenges experienced by DES participants under the increasingly compliance driven, welfare to work reforms were then described. Inspired by NPM philosophies, these reforms assume that increasing competition and contestability within the DES quasi-market, including through increased participant choice and control, will lead to more efficient and effective DES providers, and, improved employment outcomes for participants. Such assumptions disregard the complex life circumstances and broader structural barriers often experienced by DES participants with psychosocial disability, which can complicate both decision-making processes, and, access to employment. The next chapter introduces the two main conceptual models guiding this research.

Chapter Four: Conceptual framing

This chapter presents the two main conceptual frameworks utilised in this study. The first framework presented is Szymanski and Hershenson's *Ecological Model for Vocational Behaviour and Intervention for People with Disabilities* (Szymanski et al., 2012; Szymanski & Hershenson, 2005). This framework has been drawn upon to examine processes by which individual, cultural and societal level factors may interact to influence employment pathways, engagement with DES, and, employment outcomes for DES participants with psychosocial disability. The second framework presented is the *CHIME Personal Recovery Model* (Bird et al., 2014; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). This framework was used throughout the study to explore constructs that are relevant to the mental health and well-being of DES participants with psychosocial disability, as well as helping to understand the impact of engagement with DES and employment on mental health and personal recovery.

4.1 Szymanski and Hershenson's Ecological Model for Vocational Behaviour and Intervention for People with Disabilities.

Career development theories date back to the early 1900s (Strauser, 2013). In 1909 Frank Parsons proposed the first theory related to occupational choice which focused on the process of matching individual attributes to particular job requirements. Parsons' theory assumed that once a match and choice had been made, an individual would remain in the chosen occupation for life (Ritter et al., 2013; Strauser, 2013; Szymanski et al., 2012). It wasn't until the 1950s that developmental approaches to career development began to emerge that recognised that an individual's career was a *'a lifelong process involving psychological, sociological, educational, economic, and physical factors, as well as chance factors that interact to influence the career of the individual'* (D. Brown, 2007, p. 14).

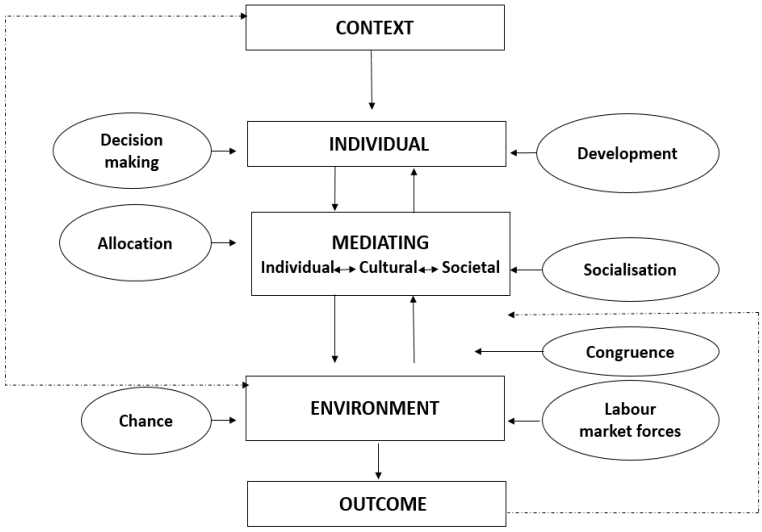
Developmental approaches were followed by a rise in work adjustment and behaviour theories, which bring together constructs of work personality (e.g. individual work abilities and work-related needs), and, matches these with congruent work environments predicted to contribute to work satisfaction (e.g. ability to perform and find satisfaction in a job) (Ritter et al., 2013; Strauser, 2013). More recently, person-environment models have emerged, recognising the inter-relationships between contextual factors and career development (Ritter et al., 2013; Strauser, 2013; Szymanski et al., 2012). Yet, many of these models fall short in relation to understanding the career

development and employment outcomes for people with disabilities (D. Brown, 2007; Szymanski et al., 2012; Szymanski & Hershenson, 2005).

In response to this recognised gap, Szymanski and Hershenson (2005) developed the *Ecological Model for Vocational Behaviour and Intervention for People with Disabilities* (herein referred to as *Szymanski and Hershenson's Model*) (Szymanski et al., 2012). *Szymanski and Hershenson's Model* is an ecological model which encompasses individual, cultural and societal level factors which are known to interact to influence employment pathways and outcomes for people with disabilities across their life course (Onken, Craig, Ridgway, Ralph, & Cook, 2007; Szymanski et al., 2012). It was developed to support the understanding of the career development of people with disabilities, as well as to help in the design and evaluation of interventions aimed at improving employment outcomes (Szymanski et al., 2012; Szymanski & Hershenson, 2005; Szymanski & Vancollins, 2003).

The underlying proposition of the model is that career development is determined by the interaction of five main constructs: **1) Individual constructs** (e.g. gender, impairment); **2) Contextual constructs** (e.g. policy context, socio-economic factors); **3) Mediating constructs** (e.g. individual work personality, cultural beliefs, discrimination); **4) Environmental constructs** (e.g. accessibility of workplaces, recruitment processes); and, **5) Outcomes constructs** (e.g. access to employment, job satisfaction) (Szymanski et al., 2012). Interactions between these constructs are influenced by a number of processes across a person's lifetime: **i) Congruence** (e.g. match between individual and work environment/role; **ii) Decision-making** (e.g. career related choices); **iii) Development** (e.g. systematic changes over time); **iv) Socialization** (e.g. how people learn work and life roles); **v) Allocation** (e.g. channelling of individuals in certain career directions); **vi) Chance** (e.g. unforeseen occurrences); **and, vii) Labour Market Forces** (e.g. economic and business forces that influence employment opportunities) (Szymanski et al., 2012; Szymanski & Vancollins, 2003). See Diagram 1 below, which is followed by a brief description of each construct and process.

Diagram 4.1 Szymanski and Hershenson's *Ecological Model for Vocational Behaviour and Intervention for People with Disabilities*



Source: Adapted from Szymanski, E., Enright, M., & Hershenson, D. (2012). Chapter 8. An ecological approach to the vocational behavior and career development of people with disabilities. In R. M. Parker & J. B. Patterson (Eds.), *Rehabilitation counseling: Basics and beyond* (5th ed., pp. 232). Austin, Tex: PRO-ED.

Key constructs in *Szymanski and Hershenson's Model*

1) Contextual constructs

Contextual constructs encompass factors which influence the circumstances in which a person lives or has lived, such as socio-economic status, family, education, and, the legislative and policy context (Szymanski et al., 2012). As highlighted in the previous chapters, the contextual environments in which people with psychosocial disability live are shaped by policies and programmes that span across the areas of health, mental health, education, housing, social inclusion, law enforcement and justice, and, importantly for this research, welfare and employment. Within policies and programs, people with psychosocial disability often experience significant challenges accessing the services and supports they require to meet their needs and reach their full capacity. This in turn influences access to employment (NMHCCF, 2011; WHO & World Bank, 2011).

2) Individual constructs

Individual constructs include the inherent attributes of a person. These include gender, ethnicity, physical and cognitive abilities, as well as individual interests, needs and values that may influence

employment outcomes (Szymanski et al., 2012). In the Australian context for example, labour force participation has been shown to be influenced by both gender and level of impairment, with men with disabilities more likely to be in the labour force than women with disabilities (56.1% vs. 50.7%). These differences remain when extended to severity, with men with profound impairments remaining more likely to be in the labour force than women with the same level of impairment (31.0% vs. 23.6%) (ABS, 2019). Earlier research has also found differences in employment outcomes between Australians with different types of mental illness. As such, people with schizophrenia were found to have lower employment rates (16.3%), compared to people with depression (36.2%), or anxiety disorders (45.4%) (R. King et al., 2006; Matthews, Harris, Jaworski, Alam, & Bozdag, 2014).

3) Mediating constructs

Mediating constructs include individual, cultural and societal beliefs that impact on the interaction of people with disabilities with their environment (Szymanski et al., 2012). Individual beliefs may include self-efficacy and an individual's self-expectations of what they may be able to achieve in relation to employment. Eklund (2007) in her study investigating the relationship between perceived control and occupational performance in people with mental illness for example, found those with higher levels of perceived control had higher levels of engagement and satisfaction within their occupational roles. Self-efficacy however is known to be mediated, and indeed undermined, by cultural and societal beliefs around the capacities of people with disabilities (Szymanski et al., 2012). As highlighted in Chapter Two, societal beliefs about the capacities of people with disabilities, plays a significant influence on the quality and access to educational opportunities, which in turn influences employment outcomes. This relationship has been shown to be of particular concern for people with psychosocial disability, whereby the onset and episodic nature of mental illness, is compounded by barriers within the education system that make it difficult for this cohort to remain engaged with schooling (Orygen National Centre of Excellence in Youth Mental Health, 2016; Orygen Youth Health Research Centre, 2014; Simonsen et al., 2013).

Negative assumptions about the work capacity of people with disabilities, including those with psychosocial disability, similarly contribute to discriminatory barriers to work. In 2015, more than one in four working-age Australians with disabilities who had experienced discrimination in the previous 12 months reported their employer as the source of discrimination (27%), and around one in six reported work colleagues as discriminatory (18%) (ABS, 2016; AHRC, 2016; AIHW, 2017). The episodic nature of mental illness can further lead to gaps in the employment history of individuals, which can be difficult to explain to a potential employer, and, may compound prejudicial perceptions of employers about the work capacity of people with mental illness. Job seekers who

have experienced discrimination when trying to find work, or in the workplace itself, can then find it very challenging to continue to pursue employment (Orygen Youth Health Research Centre, 2014). The fear of discrimination can also create disincentives for employees to disclose disability and/or mental illness, and therefore may mean they do not access support to which they are entitled and which may help them maintain employment (AHRC, 2016; Parletta, 2015).

4) Environmental constructs

Environmental constructs focus on the elements and structures in work and other environments (communities) that influence and are influenced by individual behaviours and outcomes (Szymanski et al., 2012; Szymanski & Vancollins, 2003). This includes job task requirements and, the physicality and accessibility of the work environment which may hinder or enable the access and work function of people with disabilities. It also relates to the provision or lack thereof of reasonable accommodations to support workers with psychosocial disability (Zafar, Rotenberg, & Rudnick, 2019). In comparison to physical disabilities, employers are often less aware of how (and therefore less willing) to provide reasonable accommodation (e.g. flexible working and communication arrangements, supportive co-worker and mentoring schemes, workplace awareness training, access to quiet spaces) for workers with psychosocial disability (Zafar et al., 2019).

5) Outcome constructs

Outcome constructs refer to the behaviours or states of being of individuals which are influenced by the interactions of the other groups of constructs. These outcomes include job satisfaction and satisfactoriness, job stress, occupational attainment, and organizational productivity and competitiveness (Szymanski et al., 2012). Job stress and satisfaction has been shown to be influenced by the experience of disability (LaMontagne, Krnjacki, Milner, Butterworth, & Kavanagh, 2016; Milner et al., 2019). Australian research by La Montagne et al. (2016) for example, found workers with disabilities were more likely to report experiences of poorer psychosocial job quality and adversities (e.g. low job control, high demands, insecurity, low fairness of pay) when compared to workers without disabilities.

Processes influencing constructs in *Szymanski and Hershenson's Model*

i) Development

Development refers to the systematic changes that occur over a person's life in relation to their career development and career, which are influenced by personal characteristics as well as a person's environment (Szymanski et al., 2012). The exclusion experienced by people with disabilities, including psychosocial disability, across multiple life domains and stages, can significantly disrupt development in relation to careers. This includes key opportunities that support general development and career development, such as, opportunities for play and developing social skills; undertaking household chores; independence such as learning to navigate public transport; and, gaining work experience and after school jobs (Children with Disabilities Australia, 2015; Orygen Youth Health Research Centre, 2014; Simonsen et al., 2013; Szymanski et al., 2012).

ii) Decision-making

Decision-making relates to the process by which individuals consider employment options and career alternatives to make career decisions (Szymanski et al., 2012). It is widely recognised that many people with psychosocial disability or other cognitive impairments, have experienced restrictions in their ability to exercise choice and control throughout their lives (Arstein-Kerslake, Watson, Browning, Martinis, & Blanck, 2017; Brophy, Bruxner, Wilson, et al., 2014). Restriction on autonomy and decision-making has been linked to legislation denying legal capacity;[8] institutionalisation and other forms of segregation; attitudinal beliefs around the capacity of people with disabilities; and, exclusion of the voice of people with disabilities in research and policy reform processes (Arstein-Kerslake, 2017; J. Jenkinson, 1993; Lustig, 2014). Restriction on decision-making across a person's life course, greatly impacts on career development and aspirations, as well as career decision-making processes (Lustig, 2014; Simonsen et al., 2013; Strauser, 2013).

iii) Socialization

Socialization relates to the influences which shape a person's work and life roles. One way that this is influenced is through role modelling (Szymanski et al., 2012). Because of the barriers to work and the subsequent low employment rates of people with disabilities, there is often a lack of positive

[8] For example, according to the Australian Electoral Commission, at any one time 6,000 – 16,000 people are considered to be of 'unsound mind' and excluded from voting or have restrictions placed on their engagement with voting (i.e. voting by proxy).

role models of people with disability who are working. Young people with disabilities are therefore less likely to see employment as an option, further impacting on job confidence, aspirations, career development and access to employment (Lustig, 2014; Simonsen et al., 2013; Szymanski et al., 2012). Further, many persons with psychosocial disability experience barriers to broader community inclusion. This can in turn limit social networks which are important to socialization processes and career networks (Salzer & Baron, 2016; Simonsen et al., 2013; Szymanski et al., 2012).

iv) Allocation

Gatekeepers such as parents, teachers, health and vocational rehabilitation workers, often use extrinsic criteria to allocate, channel into, or exclude people with disabilities from certain educational, training and skills development opportunities (Saleh & Bruyère, 2018; Szymanski & Hershenson, 2005). For example, students with disabilities in Australia are often channelled into educational and skills streams that don't meet their aspirations. This is a particular issue for students during the school to post-school life transition (Children with Disabilities Australia, 2015). It also relates to the issue that many people with disabilities continue to be encouraged (including within the DES program) to undertake numerous courses in vocational skills training that do not necessarily meet their aspirations, or, lead to employment outcomes, particularly in the context of the limited supply of jobs (Smith-Merry et al., 2019).

v) Congruence

Congruence relates to the match between an individual's job and the tasks they are asked to perform, with, their self-efficacy, skills and qualifications, and, capacity to perform work-related tasks. Where these align well, job congruence and satisfaction are thought to increase (Szymanski et al., 2012). Congruence can also relate to the match between an individual's social roles, values and beliefs, and, organisational values and beliefs. If there is alignment between an individual's values and beliefs and the organisation they work for, motivation and job satisfaction are more likely to be positively influenced (Gottfredson & Holland, 1990; Szymanski et al., 2012; Szymanski & Hershenson, 2005; Vigoda & Cohen, 2003).

vi) Chance

Chance refers to occurrences of unforeseen events or encounters. Whilst chance itself cannot be controlled, positive chances may be enhanced for people with disabilities through promoting social inclusion and access to opportunities. For example, individuals may be exposed to more knowledge

of work opportunities, if they have had the opportunity to engage with wider social networks. Conversely, the more socially isolated individuals are, the less chance they have to make connections with people or to be exposed to a variety of work roles and/or experiences (Salzer & Baron, 2016; Simonsen et al., 2013; Szymanski et al., 2012).

vii) Labour Market Forces

Labour market forces incorporate economic and business factors that impact on the quantity, quality and types of jobs available, as well as relative job security, impacting on both individuals and organisations (Szymanski & Hershenson, 2005). These forces are wide reaching and include globalization, casualization, technologies, organisational changes, and the health of the economy (Szymanski et al., 2012; Szymanski & Hershenson, 2005). Such forces often make it more difficult for people with disabilities to find work. For example, globalization contributes to flatter local labour markets, an increasing demand for skilled workers, and increasing competition for fewer low skilled jobs. This particularly impacts on people with disabilities who may have fewer skills due to disrupted or poorer educational outcomes, and, are often the first to be let go during redundancy processes (AHRC, 2016; DEEWR, 2014; National Disability Services, 2016; Strauser, 2013; Szymanski et al., 2012).

In summary, *Szymanski and Hershenson's Model* provides a very useful ecological framework to examine how different life circumstances and contexts may influence the employment pathways of DES participants with psychosocial disability, their engagement with DES, and the current and future access to employment. In this research, I also seek to increase understanding of how engagement with the DES program and employment may influence the mental health and well-being, and, broader life circumstances of DES participants with psychosocial disabilities, and have therefore drawn on the *CHIME Personal Recovery Model* to further examine these relationships.

4.2 The CHIME Personal Recovery Model

The concept of personal recovery emerged in the 1980s and 90s through the writings of consumers of mental health services. It was defined by Anthony in 1993 as *'a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles … a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness'* (Anthony, 1993, p. 19). This represented a shift in focus away from the medicalisation and amelioration of symptoms associated with mental illness ('recovery from'), towards, a person-focused definition of living well with mental

illness (Leamy et al., 2011). As such, personal recovery can be distinguished from clinical recovery in being less focused on symptom reduction and more on well-being and having a flourishing life ('recovery in') (Anthony, 1993; Stuart, Tansey, & Quayle, 2017).

Similar to the disability rights movement, proponents of personal recovery recognise the need to mitigate environmental barriers that impact on people living with mental illness, rather than focusing on individual impairments and health conditions (Salzer & Baron, 2016). Early conceptualisations of personal recovery were strongly influenced by notions of empowerment, self-determination and choice, with a practical focus on developing self-management, self-advocacy, and self-awareness skills sufficient to exert informed choice, as well as reclaiming rights to a safe, dignified and personally meaningful life within communities, whilst living with mental illness (Leamy et al., 2011; Shanks et al., 2013; Simonsen et al., 2013).

Like disability, recovery can be seen as occurring along a continuum, with various factors and processes influencing where and how a person may identify along that continuum. Journeys of recovery are therefore unique to each individual, and, are best determined by each individual (Slade & Longden, 2015). Similarly, individuals may see themselves at different stages of recovery and can follow different, non-linear trajectories (recovered, living well, making progress, surviving day-to-day) (Llewellyn-Beardsley et al., 2019). Importantly, recovery may occur within or external to services and systems, with some individuals choosing not to engage with mental health services and/or other welfare systems (Mental Health Commission of New Zealand, 1998; Slade et al., 2014; Slade & Longden, 2015).

There is substantial evidence which highlights the importance of work in facilitating both personal and clinical recovery (Bush et al., 2009; Slade & Longden, 2015). Work supports an individual's economic security and improves their standard of living. This in turn facilitates access to factors which inherently support physical and mental health, such as housing, transport, and, health and mental health services. Work also helps to provide structure to people's daily lives, as well as contributing to a person's sense of self and social connectedness (AHRC, 2016; Kavanagh et al., 2016; Milner et al., 2014).

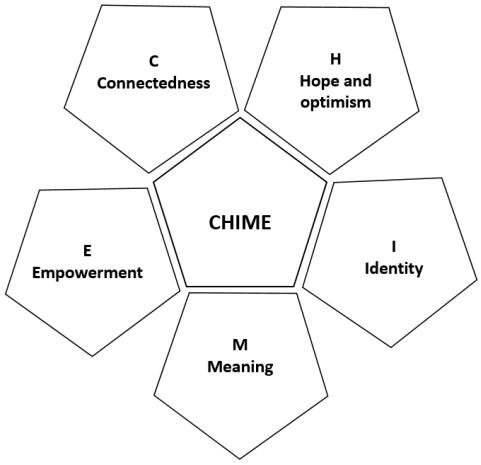
The mixed recognition of the important role employment can play in supporting recovery, however, is reported to undermine both the recovery of individuals, and, access to employment for people with psychosocial disability. Whilst most evidence suggests getting people into employment facilitates personal recovery, many health and employment providers often advocate that people need to be 'well' before they attempt to gain employment (Orygen Youth Health Research Centre,

2014). Similarly, some health and employment services may not prioritise employment for people that they perceive or misinterpret as lacking motivation, or, when there is a concern that work-related stress may contribute to a person's mental illness (Parletta, 2015).

In recent decades, the concept of personal recovery has increasingly been drawn upon to inform recovery-orientated practices and service delivery. Recovery-orientated practice aims to deliver services that recognise the uniqueness of individuals, empowering them to make choices about what recovery means to them and how they want to engage with services and receive supports that facilitate their personal goals (Farkas, Gagne, Anthony, & Chamberlin, 2005; Le Boutillier et al., 2011; Mental Health Standing Committee, 2010; Slade, 2010).

To formalise a model of recovery to support research and recovery-orientated practice, Leamy and colleagues conducted a systematic review and narrative synthesis on personal recovery in mental illness (Leamy et al., 2011). The review examined 97 papers across 13 countries with populations recruited from diverse settings (e.g. community mental health facilities, self-help groups) with the aim of identifying unifying themes of recovery. The resulting *CHIME Personal Recovery Model* identifies five key dimensions of recovery: 1) Connectedness; 2) Hope and optimism in the future; 3) Identity; 4) Meaning and purpose in life; and, 5) Empowerment (Leamy et al., 2011, p. 449). See Diagram 1.2 below, which is followed by a brief description of these five key dimensions.

Diagram 4.2 The *CHIME Personal Recovery Model*



Source: Adapted from the Scottish Recovery Network, accessed 1 February 2020: https://www.scottishrecovery.net/what-helps/

1) Connectedness

Connectedness relates to the personal connections individuals experience with other individuals. When these connections are supportive of individuals, they can enhance journeys of recovery (Leamy et al., 2011; Tew et al., 2012). Connections may be formed or nurtured through peer support and support groups, as well as within services delivered by professionals (Mental Health Commission of New Zealand, 1998). Intimate and non-intimate positive relationships with friends and family are similarly recognised as vital components of connectedness for many people with psychosocial disability. Being part of and contributing to community are also central to the construct of Connectedness (Bird et al., 2014; Leamy et al., 2011). This can include the social participation and sense of community attained though work (Milner et al., 2014; Provencher et al., 2002). Increased connectedness through volunteering has also been found to support well-being (K. Brown, Hoye, & Nicholson, 2012). Furthermore, the more connected an individual is within their communities, the more likely they are to be exposed to positive career development processes, such as socialization (Simonsen et al., 2013).

2) Hope and optimism in the future

Hope and optimism that a better future is possible are recognised as fundamental to the processes of helping people find the courage to initiate a journey of recovery, and, the motivation and resilience to maintain a positive focus on recovery, and, make the necessary changes to progress recovery (Bird et al., 2014; Schrank, Bird, Rudnick, & Slade, 2012). Facilitating factors include hope-inspiring relationships, positive thinking and valuing success, and, having dreams and aspirations. (Leamy et al., 2011). In turn, approaches within recovery-orientated practice recognised as supporting hope and optimism include fostering relationships and peer support, alongside interventions that promote self-esteem, self-efficacy, and well-being. Supporting service users to exercise choice and control, particularly in relation to determining meaningful and realistic goals (including career and employment related goals) are similarly recommended (Anthony & Mizock, 2014; Schrank et al., 2012).

Connecting with *Szymanski and Hershenson's Model,* greater recognition of the latter, could help workers within employment services nurture the decision-making processes of participants, as well as reduce allocation into education and employment that do not align with the skills and aspirations of individuals (Szymanski & Vancollins, 2003). Furthermore, hope-inspiring relationships are acknowledge as providing opportunities for role-modelling, which is similarly recognised as

important to the career development of people with disabilities (Leamy et al., 2011; Szymanski et al., 2012)

3) Identity

Dimensions of identify incorporate gender, sexuality, ethnicity and cultural identity, as well as how individuals may identify as part of a collective, such as within the disability and consumer led mental health movements. (Leamy et al., 2011). For some, having a diagnosis is an important aspect of their identity. For others, it may be a minor component or not relevant to their identity (Bird et al., 2014). Within the process of recovery, building self-esteem and acceptance of one's experiences is seen as part of helping individuals to rebuild or redefine a positive sense of self (Leamy et al., 2011).

Over-coming and addressing stigma at an individual and societal level is seen as a critical component of recovery-orientated practice, as well as an important mediator in addressing employment barriers experienced by people with disabilities (Farkas et al., 2005; Murfitt, Crosbie, Zammit, & Williams, 2018; Szymanski et al., 2012).

4) Meaning and purpose in life

Meaning and purpose in life is a broad dimension encompassing various inter-related components (Bird et al., 2014; Leamy et al., 2011). Components include finding meaning in the experiences of living with mental illness, both in terms of acceptance, and, the recognition that many people learn new insights and gain skills which may not have been made available to them without the experiences associated with having a mental illness (Bird et al., 2014; Schrank et al., 2012). Quality of life is another critical component of this dimension, with contributing elements recognised as well-being, the ability to meet ones basic needs, education, recreation, and, access to work and volunteering opportunities (Doroud, Fossey, & Fortune, 2015; Leamy et al., 2011). Linking to connectedness, having meaningful life and social goals, as well as participating in activities and routines that help individuals work towards these goals and rebuild their lives, are further seen as important to finding meaning and purpose in life. For many, work contributes significantly to the sense of meaning in their lives (Bird et al., 2014; Tew et al., 2012).

5) Empowerment

The final dimension is Empowerment, with elements that contribute to the sense of empowerment often differing between individuals (Bird et al., 2014; Leamy et al., 2011). For some, empowerment within recovery relates to taking personal responsibility over one's life, including maintaining health

and well-being in the support of self-managing their condition, focusing on strengths, and, utilising individual coping skills and resilience. For others, empowerment directly relates to having control over one's life, including in relation to exercising choice and control in whether and how they engage with services (Bird et al., 2014; Brophy, Bruxner, & Wilson, 2014; Leamy et al., 2011).

As observed within *Szymanski and Hershenson's Model,* self-efficacy is an important mediator in the career development of people with disabilities (Szymanski et al., 2012; Szymanski & Vancollins, 2003). Access to employment, and, choice and control in relation to employment are further recognised as contributing to the empowerment of people with mental illness and disability, which in turn, can promote recovery (Callahan & Mank, 1998; Eklund, 2007; Provencher et al., 2002).

In summary, the CHIME model has an emphasis on recognising and valuing all individuals as people with hopes, dreams, desires and capabilities, rather than focusing predominantly on health conditions, impairments and barriers (Salzer & Baron, 2016). This highlights the importance of support services (health and employment services), as well as the broader community, having the expectation that people with psychosocial disability can recover and achieve. Positive expectations should then help inform recovery-orientated practice and the way in which services support individuals to lead their own recovery, including enabling them to have choice and control in relation to employment (Salzer & Baron, 2016; Scanlan, Feder, Ennals, & Hancock, 2019; Slade et al., 2014).

Whilst recovery and recovery-orientated practice are not currently mentioned within DES policy and programming documentation, incorporation of such practices within DES have the potential to support both mental health and employment outcomes (J. King & Waghorn, 2018; Scanlan et al., 2019). This is particularly so given the high proportion of DES participants whose main condition is reported to be psychosocial disability (DSS, 2020). The CHIME recovery model is therefore complementary with *Szymanski and Hershenson's Model* in this research, to more specifically explore how DES participants with psychosocial disability experience recovery within their engagement with DES.

Chapter summary

This chapter presented the *Szymanski and Hershenson's Model,* and, the *CHIME Personal Recovery Model*, as the two main conceptual models utilised in this study. *Szymanski and Hershenson's Model* ecological and life course approach, enables examination of individual, cultural and societal level constructs and process which influence employment pathways and outcomes for people with disabilities. The *CHIME Personal Recovery Model* takes a more individualistic approach to examine

dimensions which influence the personal recovery of people with mental illness and/or psychosocial disability.

Understanding and supporting the career development and employment of people with psychosocial disability can promote personal recovery. Conversely, people experiencing good mental health are more likely to gain and maintain employment. Both these relationships are influenced by the broader context in which people live, and, whether this context facilitates or creates disabling barriers to people's mental health, and, access to employment. Together, the two models provide a complimentary framework to examine the experiences of DES participants with psychosocial disability in relation to their life circumstances, mental health, employment, and, engagement with the DES program. Integrating components of each model also enables a richer analysis of how the key concepts specifically explored in this research, such as mental health, are influenced across the life course of individuals, which, in turn can influence career development. For example, within the contextual and mediating constructs of *Szymanski and Hershenson's Model*, one can examine how experiences of discrimination and bullying within the education system, may influence an individual's sense of connectedness and identity throughout their lives. In turn, one can explore how these dimensions of the *CHIME Personal Recovery Model* influence the development of an individual's self-belief and their career development journey. The following chapter, details the mixed methods utilised to implement this research.

Chapter Five: Methods

The aim of this PhD study is to explore the relationships between the life circumstances of DES participants with psychosocial disability and their engagement with the federal government funded DES program. This chapter details the research questions and the mixed methods approach utilised in the study. The PhD was embedded within the Australian Research Council Linkage Project Improving Disability Employment Study (IDES), which aims to improve understanding of factors that promote sustainable and meaningful employment outcomes for people with disabilities. The IDES project involves the implementation of a two wave quantitative survey with individuals with disabilities engaged with government funded employment services, of which the first wave of data was analysed as part of this PhD. Alongside the IDES survey, I conducted qualitative interviews with DES participants with psychosocial disability. Interviews focused more specifically on participants' life circumstances, and, how these circumstances influenced, and were influenced by, their engagement with DES. The description of the quantitative and qualitative methods used is followed by an overview of the analysis techniques, ethical considerations, and, participant demographics.

5.1 Research questions

The specific research questions this PhD study aims to answer are:

1. What are the life circumstances of DES participants with psychosocial disability including i) demographic and socio-economic characteristics, ii) levels of health and well-being, and, iii) experiences of employment?

2. What are the vocational and non-vocational barriers and enablers to employment experienced by DES participants with psychosocial disability?

3. What are the most effective mechanisms by which DES providers can address vocational and non-vocational barriers to employment to help participants with psychosocial disability gain and maintain employment? What are the key enablers and barriers in this process?

4. Do DES participants with psychosocial disability perceive they have 'choice and control' in their engagement with DES providers? Is this changed by the 2018 DES reforms which aim to improve choice and control?

5. How do the life circumstances of DES participants with psychosocial disability change through their engagement with DES providers? Is this changed by the DES sector 2018 reforms?

5.2 Mixed methods interpretivism and approach

The IDES project team this PhD is embedded within brings together researchers from diverse disciplines, who align interpretivist theoretical stances with that of post-positivism. Similarly, the IDES project and this PhD research is mixed methods in its design, integrating both quantitative and qualitative methods of data collection, analysis and interpretation throughout the research process (Creswell, 2011; Giddings & Grant, 2006; Halcomb, 2019). As such, the thesis draws on qualitative methods and interpretivism to privilege and mediate the voice and perspectives of people's lived experience of psychosocial disability, and, how they frame their own realities within the context of their engagement with DES (Creswell, 2011; Ritchie, Lewis, Nicholls, & Ormston, 2013). This has been integrated with the post-positivist position that a full understanding of phenomena also requires researchers to draw on the breadth of data generally offered by quantitative techniques to explore the complex and often cyclical relationships between socio-economic conditions (as both causes and consequences) and actions of individuals and systems, and, subsequent effects and outcomes (Creswell, 2011; Giddings & Grant, 2006).

This blending of theoretical stances has been referred to by some researchers as Mixed Methods Interpretivism (Creswell, 2011; Howe, 2004). Howe (2004), in his critique of dominant paradigms within educational research, defined Mixed Methods Interpretivism as a paradigm *'which elevates the voice of research participants to a primary position and thereby reverses the epistemological ordering of quantitative-experimental and qualitative interpretivist methods'* (Creswell, 2011; Howe, 2004, p. 1). Indeed, whilst the thesis draws on both the quantitative and qualitative methods concurrently wherever possible, the qualitative data and voices of qualitative participants has to some extent been privileged. This is reflected in the results presented in Chapters Six and Seven, which draw solely on the qualitative components of the research. Chapters Eight and Nine, and, the discussion in Chapter Ten, more fully integrate the data generated by the different research methods used (Giddings & Grant, 2006).

Overall, integrating the breadth of the quantitative data with the depth of the qualitative data has enabled the research questions to be more fully explored, as well as allow for triangulation (Creswell, 2011; Doyle et al., 2009; Giddings & Grant, 2006; Halcomb, 2019). Quantitative findings on housing for example, were able to be contextualised and illuminated in relation to participants' lived experience as captured in the semi-structured interviews. Conversely, qualitative findings describing housing challenges, were able to be triangulated with analysis of the IDES survey data. It was also

assumed that some DES participants would have a preference for how they participate in the IDES project. By providing for both quantitative and qualitative options, we hoped to capture the perspectives of as many diverse DES participants as possible.

5.3 Quantitative methods

The IDES project

The IDES project is implemented by the Chief Investigators on the ARC grant in partnership with service provider peak bodies, employment service providers and disability advocacy bodies.[9] The objectives of the IDES project were to understand and document:

1. The aspirations of jobseekers with disabilities regarding employment and their expectations of employment services and workplaces.
2. The individual and service-related characteristics that enable the realisation of expectations and aspirations.
3. For jobseekers that obtain employment, the characteristics of workplaces, jobs and employment services that contribute to sustainable and meaningful employment.
4. The relationships between employment outcomes and social and economic wellbeing.

IDES survey development

The IDES survey was developed by the IDES research team, including myself, in consultation with partner organisations, and, the Social Research Centre (SRC, a subsidiary of the Australian National University) who were contracted to implement the survey. The IDES survey was designed to include questions across a number of domains thought to influence and be influenced by employment outcomes. Domains include demographics, socio-economic characteristics, disability and functioning, current and previous employment, engagement with employment services, health and well-being, housing and transport. Where possible, previously validated survey questions were used or adapted for inclusion in the IDES survey (Dimov et al., Under review). (See Table 5.1 on pg. 46, and, Appendix 1. IDES survey on pg. 195).

The SRC conducted cognitive testing of the survey with nine DES participants with disabilities, recruited with the support of one of the DES research partners. Survey refinement and pilot testing was then conducted in February 2018 with 32 DES participants with disabilities, recruited with the

[9] For more information of the IDES research, please see www.ides-study.org.au

support of seven DES research partners. The survey was then finalised prior to implementation in April 2018.

Table 5.1: IDES survey domains and source of items

Domain	Examples of data items	Source of items derived
Demographics	Gender, age, household composition, ethnicity, language, education	-Adapted from Survey of Disability, Ageing and Carers (SDAC)(Australian Bureau of Statistics, 2015b) and; -Household, Income and Labour Dynamics in Australia (HILDA)(Wilkins & Wooden, 2013)
Functioning & disability	Main type of impairment/s identified (e.g. physical, psychosocial, intellectual)	IDES team developed
	Difficulties with functioning (e.g. vision, hearing, mobility, remembering, communication, self-care, pain, fatigue, affect (depression and anxiety)	-Washington Group (WG) Short Set and Extended Set (Washington Group on Disability Statistics, Budapest Initiative, & United Nations Economic & Social Commission for Asia & the Pacific, 2010)
Employment Services	Referral into services, expectations of services, skills and aspirations, vocational and non-vocational barriers to work, reasons for wanting to work, experiences of discrimination, and, social networks	-Adapted from Life Opportunities Survey (Cuddeford, Duncan, Howe, & Glen, 2008); and -IDES team developed items
Employment history	Current and previous paid work history, roles, number of hours worked, duration, volunteering experience, reasons for leaving paid employment (if applicable)	-Adapted from HILDA
Health and Well-being	Self-rated health	-Selected items from the Short-Form 12 Questionnaire (C. Jenkinson & Layte, 1997)
	Mental health (self-ratings across symptoms of depression, anxiety, positive affect, general distress, behavioural control)	-Mental Health Inventory – 5 item (MHI-5) (Rumpf et al., 2001)
	Well-being (e.g. self-rating of satisfaction with standard of living, health, achieving in life, safety, relationships, community connectedness and future security.)	-Personal Well-being Index (PWI)(Cummins & Lau, 2005)
	Decision-making (e.g. how much choice do you have in how you spend your time)	-IDES team developed items
Housing	Type of housing, experiences of sleeping rough, number of times having to move	-SDAC -HILDA

	due to disability/health condition, household access to internet	-Life Opportunities Survey (LoS) -IDES team developed items
Transport	Access to transport, difficulties in using transport	-SDAC -HILDA -LoS -IDES team developed items
Financial resources	Household income, source of income, welfare payments received, access to NDIS package, financial difficulties (e.g. difficulty paying bills due to shortage of money)	-SDAC -HILDA -LoS -IDES team developed items

IDES survey participant recruitment

Prior to recruitment, front-line staff from the nine partner DES providers and one mainstream (*jobactive*) provider were trained by the SRC and IDES project manager. This was done face-to-face or via webinar depending on the availability and preference of the partners. The training included an overview of the project, recruitment process, and ethical considerations including secure recording of participant details and ascertaining capacity to provide informed consent (See Appendix 2 Capacity to consent checklist, pg. 230). Partner organisations worked with the SRC and research team to select a number of metropolitan and rural sites, with geographical coverage across five states (Victoria, New South Wales, Queensland, Western Australia and Tasmania).

Participant recruitment for Wave 1 commenced on 5 April 2018 and continued until 10 December 2018. Initially, frontline staff were tasked with identifying potential survey respondents. Frontline staff provided potential survey respondents with information about the IDES survey using a project script and provision of the study's Plain Language Statement. If individuals expressed interest and capacity to provide informed consent was ascertained, frontline staff asked for consent to pass on their contact details to the SRC via an online enrolment form. The SRC then made contact with each potential participant, provided details of the survey and participation requirements and again ascertained informed consent from interested individuals. Survey respondents were given the option to complete an online version of the survey using a link provided, or, via Computer-assisted Telephone Interview (CATI).

Recruitment via frontline staff described above resulted in 103 potential survey respondents being provided information on the study, 70 of whom agreed to be contacted by the SRC. Of these, 32 individuals completed the survey. Given the low number of participants being recruited in this way,

the research team, SRC and seven partner employment providers agreed to expand recruitment with the use of an email link sent out to DES clients.[10] The email link was sent to 6,722 DES clients. DES partners who did send out the email link to clients reported considerable unsuccessful delivery of the email, but the actual number of unsuccessful email deliveries was not provided back to the research team by services. It is therefore not possible to know how many potential participants received the invitation to participate.

A total of 297 DES participants (no *jobactive* participants completed the survey) completed the online survey, with four survey respondents completing the survey via CATI. A small number of individuals also contacted the IDES project manager requesting to participate in the study. Overall, a total of 337 individuals completed the survey over the Wave 1 period (5 April 2018 to 10 December 2018). Of these, 38 individuals completed the interview via telephone and were 299 individuals self-completed the survey online. Each survey took on average 42 minutes to complete. All survey respondents, including pilot participants, will or have been invited to participate in Wave 2 of the IDES survey approximately 12 months after the date they completed Wave 1 (Dimov et al., Under review). Only Wave 1 data is utilised in this thesis.

Key variables

Psychosocial disability

IDES respondents were defined as having a psychosocial disability through self-report (i.e. they reported their main disability was psychological), and, the Washington Group (WG) Short and Extended Sets of Questions. The WG on Disability Statistics designed these sets to identify people at risk of disability through nationally-based surveys. The Extended Set items used included pain, fatigue and affect items (e.g. anxiety and depression) with responses measuring frequency and severity of symptoms (Washington Group on Disability Statistics et al., 2010). If a person did not self-report a specific disability, they were assigned to the psychosocial disability group if their main reported difficulties across the Extended Set included daily or weekly anxiety or depression with the level reported as *'a lot'* or '*somewhere in between a little and a lot'*, and, their responses to the Short Set of questions indicated no other or less difficulties in other domains (e.g. vision, hearing,

[10] Reasons for the low enrolment using frontline staff may include the fact that the survey was being implemented just prior to and during the DES reforms. As such, the sector was undergoing significant disruptions. Three of the DES providers chose not to participate in the email send out to clients either due to resources and not having capacity to collate email address; they preferred to continue face-to-face recruitment; or, they felt their clients would not want to have their details shared or would not respond to an email invitation.

mobility, self-care, communication, remembering). The WG responses were also used to cross-check self-reported main type of disability.

Key exposure (or independent) variables

Key exposure variables included demographic and socio-economic variables including age, gender, and education. Depending on the purpose of the analysis, other key exposure variables included employment, engagement with DES, discrimination, and, housing. Demographic and socio-economic variables, and, variables on employment, discrimination, housing, and finances were adapted from the SDAC (ABS, 2016), LoS (McManus & Lord, 2012), and HILDA (Wilkins & Wooden, 2013) with some items also developed by the research team (Dimov et al., Under review). Variables on engagement with DES were developed by the research team.

Key outcomes (or dependent) variables

Key outcome variables utilised focused on mental health and well-being. Mental health was measured in the IDES survey using the five-item Mental Health Inventory (MHI-5), a subscale of the Short form-36 (SF-36) general health measure. The MHI-5 has been validated as a screening tool to detect symptoms of anxiety, depression, behaviour control, positive affect and general distress in the past four weeks. As recommended, the scores for each item are aggregated and converted to a continuous MHI-5 total score (scale 1 to 100), with higher scores representing better mental health (Rumpf et al., 2001).

The seven item Personal Wellbeing Index (PWI) was included as a validated measure of subjective well-being. The PWI items elicit respondent satisfaction across the domains of standard of living, health, achieving in life, relationships, safety, community connectedness, and, future security (Cummins et al., 2003; Cummins & Lau, 2005). A PWI total score corresponding to a continuous scale (1 to 100) was generated based on previously validated frameworks (Cummins et al., 2003; Cummins & Lau, 2005).

To test the validity of the MHI-5 and PWI in our sample, we calculated Cronbach Alpha scores for the whole of the sample, for respondents with psychosocial disability, and, respondents with other types of disability. The scores, included in Table 5.2 below, indicate that the scales function well and in a similar way across the sample. To examine measurement invariance, we conducted exploratory factor analysis to confirm the factor structure of the MHI-5 and PWI within each of the sub samples (psychosocial versus non-psychosocial) using the principal-component factor methods, and found again that the scales function in a similar way across the sample. See Table 5.3 and Table 5.4

Table 5.2 Cronbach alpha scores for PWI and MHI-5

	Whole sample Cronbach alpha	Psychosocial respondents	Respondents with other disability types
PWI	0.89	0.88	0.90
MHI-5	0.89	0.88	0.90

Table 5.3 Principle component analysis factor loadings for MHI-5 items for respondents with psychosocial disability, and, all other respondents combined.

	Respondents with psychosocial disability				**All other respondents**			
Factor	Eigenvalue	Difference	Proportion	Cumulative	Eigenvalue	Difference	Proportion	Cumulative
1	3.40	2.72	0.68	0.68	3.52	2.85	0.70	0.70
2	0.67	0.21	0.13	0.81	0.67	0.30	0.13	0.83
3	0.46	0.19	0.09	0.90	0.37	0.11	0.07	0.91
4	0.28	0.09	0.06	0.96	0.26	0.09	0.52	0.96
5	0.18	-	0.04	1.00	0.16	-	0.03	1.00
	LR test: independent vs. saturated: chi2(10) = 458.43 Prob>chi2 = 0.0000				LR test: independent vs. saturated: chi2(10) = 559.56 Prob > chi2 = 0.000			
MHI5 Item	Factor loading (pattern matrix) factor 1		Uniqueness		Factor loading (pattern matrix) factor 1		Uniqueness	
1	0.68		0.54		0.76		0.43	
2	-0.87		0.25		-0.83		0.31	
3	0.89		0.21		0.89		0.21	
4	-0.82		0.33		-0.89		0.20	
5	0.85		0.28		0.82		0.33	

Table 5.4 Principle component analysis factor loadings for PWI items for respondents with psychosocial disability, and, all other respondents combined.

	Respondents with psychosocial disability				**All other respondents**			
Factor	Eigenvalue	Difference	Proportion	Cumulative	Eigenvalue	Difference	Proportion	Cumulative
1	3.66	3.57	1.06	1.06	3.91	3.76	1.04	1.04
2	0.08	0.02	0.02	1.09	0.15	0.07	0.04	1.08
3	0.06	007	0.02	1.11	0.08	0.11	0.02	1.11
4	-0.01	0.02	-0.002	1.10	-0.03	0.03	-0.01	1.10
5	-0.02	0.13	-0.01	1.10	-0.07	0.06	-0.02	1.10
6	-0.15	0.03	-0.04	1.05	-0.13	0.05	-0.03	1.04
7	-0.18	-	-0.05	1.000	-0.18	-	-0.05	1.00
					LR test: independent vs. saturated: chi2(21) = 665.39 Prob>chi2 = 0.0000			
PWI Item	Factor loading (pattern matrix)			Uniqueness	Factor loading (pattern matrix)			Uniqueness
	Factor 1	Factor 2	Factor 3		Factor 1	Factor 2	Factor 3	
1	0.71	0.16	-0.06	0.46	0.78	-0.06	-0.16	0.36
2	0.68	-0.07	-0.06	0.52	0.70	-0.18	0.01	0.47
3	0.83	-0.15	-0.04	0.28	0.73	-0.18	0.11	0.42
4	0.68	-0.05	0.12	0.51	0.67	0.19	0.07	0.5
5	0.65	0.14	0.12	0.54	0.71	0.12	-0.16	0.45
6	0.71	-0.04	0.07	0.49	0.77	0.17	0.11	0.37
7	0.76	0.05	-0.13	0.39	0.85	-0.05	0.03	0.28

Statistical analysis

IDES survey data for the 369 survey respondents (inclusive of the 32 pilot respondents and 337 Wave 1 survey respondents) were entered into Stata 15 for analysis (StataCorp, 2017). Descriptive analysis was undertaken to identify demographic and socio-economic characteristics (age, gender, education, access to the NDIS), experiences in the labour market (access to paid work, factors impacting on access to work, discrimination), and differences between survey respondents with psychosocial disability compared to respondents with other types of impairments (i.e. respondents with physical, sensory, cognitive or multiple impairments who were grouped together for the purpose of this analysis).

Adjusting for age, gender and education (dichotomised by completed secondary school or did not complete secondary school), linear regression modelling using the MHI-5 and PWI as outcome variables were used to examine the associations between mental health and well-being and a range of exposure variables (engagement with DES and the labour market, discrimination, housing insecurity) in participants with a psychosocial disability.

5.4 Qualitative methods

In-depth interviews were conducted with 30 DES participants with psychosocial disability. Participants were divided into two cohorts of 15 individuals. The first cohort participated in the study prior to the implementation of the 1 July 2018 DES reforms, with initial interviews beginning in November 2017 and follow-up interviews conducted in May 2018. The second cohort were recruited post the reforms, with interviews beginning in September 2018 and follow-up interviews conducted between March and April in 2019.

Participants were asked to participate in two face-to-face, semi-structured interviews, with an interval of approximately six months in between interviews. Interview guides were informed by the relevant literature and research questions. In the initial interview, participants were asked about their lives including their physical and mental health; any relationship between work and their mental health; about their experiences of work (including barriers, supports and aspirations); and about their experiences with DES, including in relation to their choice and control within the DES system. (See Appendix 3. Initial interview guide, pg. 231).

In the second interview, participants were asked about any changes that had occurred in their lives since the first interview, including in relation to their life circumstances, mental health, and employment outcomes; supports they have received from their DES provider and/or others; and choice and control in their engagement within the DES program. (See Appendix 4. Follow up interview guide, pg. 234). Repeated interviews with the same participants enabled exploration of how life circumstances changed over time at the individual level, how this was influenced by engagement with DES and/or access to employment, and, by the often episodic nature of mental illness. Interviewing cohorts before and after the introduction of the DES reforms in July 2018 allowed exploration of whether the reforms contributed to differences in circumstances, experiences and outcomes between the two cohorts.

Recruitment of qualitative interview participants

Two methods of recruitment were utilised: 1) recruitment through the IDES survey, and 2) direct recruitment through the DES research partners working with clients with psychosocial disability. Potential participants for the qualitative interviews included IDES survey respondents who: 1) had given prior consent to be contacted by the research team to ascertain whether they were interested in participating in follow-up interviews, and, 2) were identified through self-report within the IDES survey as having a psychological disability. Eligible potential participants were contacted and provided with information about the qualitative interviews. If potential participants

confirmed their interest in participating, a convenient time and meeting place was arranged to conduct the interview.

Given it was envisaged that it may not be possible to recruit enough qualitative interview participants through the IDES survey, I also worked with four of the IDES partner DES providers who identified as either being a mental health specialist DES provider, or, identified as having a significant caseload of individuals with psychosocial disability and were willing to support the qualitative component of the study. DES frontline staff interact with DES participants with psychosocial disability on a daily basis. These interactions provided the opportunity for frontline staff to provide DES participants with information about the qualitative study in the form of a flyer and Plain Language Statement. Flyers advertising the project were also placed in prominent locations in partner DES facilities. During data collection, I also spent time at the offices of DES partners to engage with participants directly and provide information about the study to interested individuals. When individuals expressed interest, either directly to myself or via their provider, a time and place to conduct the interview was organised. Whilst recruitment was restricted to Victoria for financial and logistical reasons, I endeavoured to have a representative sample across urban and rural locations. Overall, eight people were recruited through the IDES survey, and 22 people were recruited directly through DES providers. Twenty-six participants completed the follow-up interview. One participant in the first cohort was lost to follow-up, whilst three participants in cohort two were lost to follow-up.

Data collection

Interviews were conducted at a time and public meeting place which was convenient to the participant, and which was relatively quiet and private. The majority of interviews were conducted at the offices of the DES partners, with a small number being conducted in a local library or café. One follow-up interview was conducted in the home of the participant as they had recently had a baby. All participants had the opportunity to participate in the interview with a support person if they wanted to, yet all chose to participate independently. All participants were 18 years or over and provided informed consent to participate before each interview commenced. Interviews took approximately 40 minutes, ranging from 15 minutes to 65 minutes in length. Interviews were audio-recorded and later transcribed by the researcher.

Qualitative data analysis

Analysis began with multiple readings of each transcript by the researcher. Transcripts were initially deductively reviewed with interpretation drawing on the research objectives, conceptual

frameworks, and, relevant literature described in Chapters Two and Three of the thesis. An inductive process was then utilised to identify further codes from the data. A thematic coding framework was then drafted based on this inductive analysis and the research objectives. The draft framework, along with a sample of de-identified transcripts were shared with the research team for their review and feedback. This enabled refinement of the framework prior to ongoing analysis. Emerging findings from the subsequent analysis were continually shared with the research team. It should be noted, however, that the lead researcher was the only team member to analysis and code all transcripts.

The progression of the analysis process diverged into two distinct processes, influenced by the stage of data collection, the research questions being addressed, and, how the findings were to be presented. For example, data were re-analysed for Chapters Five and Six, using a thematic approach to analysis as described by Braun and Clarke (2006). The qualitative analysis software NVivo was used to organise the data and support this process.

Chapters Seven and Eight are based on analysis of how participants' narratives of their lived experience emerged and evolved over time, and therefore draw upon narrative inquiry to guide the analysis (Clandinin, 2006). Narrative inquiry aims to elicit underlying narratives through analysing accounts of events occurring over time and the way these accounts are told (Bruner, 1991; Frank, 2012). Narrative inquiry has been previously used to explore various lived experiences of phenomena (mental illness, disability, supported-decision making, unemployment) and how these may interact with social factors, which in turn influence ongoing experiences (Clandinin, 2006; Ezzy, 2000; Gray, 2001; Holland, Thomson, & Henderson, 2006; Knight et al., 2018). Narrative inquiry is useful for generating a deeper understanding of how social factors may influence individuals, their actions and ongoing experiences of mental health and employment phenomena over time (Clandinin, 2006; Ezzy, 2000; Holland et al., 2006; Riley & Hawe, 2005).

Analysis checking

I was supported by the DES provider Ostara for the majority of the PhD (until their Victorian DES contracts were acquired by a new provider). This gave me the opportunity to continually discuss interpretations of the data and how they related to the broader organisational and DES program context. Plain language summaries of findings were developed and shared with qualitative interview participants and DES partners at three stages of the research. Follow-up interviews with participants also enabled clarification of my interpretations of the data with individuals to ensure accurate

understanding and interpretation. Throughout the PhD candidature, I presented components of the findings at three conferences and one industry forum, garnering feedback from both DES and mental health audiences. These processes helped with ongoing analysis and interpretation of the findings.

Ethical considerations

Ethics approvals for the IDES study and the qualitative component of this study were obtained from the University of Melbourne's Human Research Ethics Committee (ID 1545810.1 & 1750133.1). The primary ethical consideration of the research was the psychological distress participants may have experienced as a consequence of participating in the survey and/or qualitative interviews. Questions on sensitive topics such as life circumstances, experiences of disability and accessing DES providers may have provoked emotional distress when such experiences are recalled. The process of participating in the survey and/or interview may in turn have exacerbated underlying mental health conditions. To minimise this risk, interviews were conducted at a time and in a place which was convenient to the participant and where they felt comfortable and safe.

During the interview, I regularly checked in with participants about how they were feeling, and, that they are happy to continue. Distress protocols were also developed for the IDES survey and qualitative interviews in the event that a participant showed signs of distress, although these were not required during the qualitative interviews. (See Appendix 5. Distress protocol, pg. 236). The SRC reported that one interviewer raised concerns regarding the impact of the interview process on one of the respondent's welfare. The SRC team reviewed the situation and ascertained that additional escalation was not required, but that the respondent should not be contacted for Wave 2, to avoid further distress.

With prior consent, I followed-up with each of the interview participants via text message a few days after each interview to ascertain whether they had any questions or concerns as a result of participating in the interview, and, if any emotional distress had arisen. If the participant expressed distress, I followed-up with a phone call to talk through what had triggered the distress and discuss options for seeking follow-up help. In all but one instance, participants reported that they had not been distressed following the interview, and, had felt that participating in the interview had been a positive experience. One participant expressed experiencing distress, but that this was not related to participating in the interview. In this instance, the participant was contacted via telephone again a few days later to make sure they had been able to make contact with their regular support services.

Developing processes for ascertaining capacity to consent also required considerable ethical consideration. This is something both the SRC and myself have had experience with in previous

research. SRC interviewers and DES frontline staff involved in identifying potential participants and requesting consent to share details with the SRC, received training on ascertaining capacity to consent. Considerations recommended to guide this process included thorough sharing of information about the study using the PLS and the script provided by the SRC, and determining whether potential participants were able to understand: what the study is about when it was explained to them; what was going to be required of them during the study; that participation was voluntary; that refusing to participate would not impact on the services they were receiving from their employment service provider; that they could withdraw from the study at any time; and, they knew they could complain to the SRC or the University of Melbourne is they were unhappy or had concerns.

SRC interviewers and frontline staff were then asked to indicate whether to the best of their knowledge they felt the participant was able to provide informed consent. Participants were also given a copy of the PLS to keep. Survey respondents who completed the survey in response to receiving the email link were asked to read through the PLS and then complete an online version of informed consent process, noting that capacity to consent was therefore not ascertained by members of the research team. These respondents were however provided with the contact details of the SRC so they could make contact if they had any questions or concerns, or, wanted to complete the survey via interview and/or required support. During the initial discussion with potential participants in the qualitative interviews, I provided information about the research and ascertained willingness and capacity to participate. I also regularly checked back in with participants to make sure they had clearly understood the information provided and/or if they had any questions (e.g. checking that they understood that following their participation they would be invited to participate in a follow-up interview, that they knew they could stop the interview at any time). (See Appendix 6. Plain Language Statement pg. 237, and, Appendix 7. Informed consent form, pg. 241).

Finally, to protect the anonymity of all participants, published or publicly available information about the research were carefully presented to minimise the chance of information being linked to individuals or DES providers. Location names, individual names, or names of the partner DES providers have not been used in published or publicly available documents (including this thesis), except on one occasion when the name of a participant was used with consent in a short publication piece. Before publishing any data in the public domain, draft manuscripts with de-identified findings were shared with the research team and research partners (where relevant) for them to assess if any

of the information could 1) link to a specific person, and/or 2) cause any harm to individuals or organisations.

5.5 Participant demographics

Just under half of all IDES survey respondents reported psychosocial disability as their main disability. Compared with participants with other disabilities, participants with psychosocial disability were more likely to be younger, female, and have achieved higher levels of schooling and post-school qualifications. The two groups were similar in the type of income support received, as well as in their type of engagement with DES (compulsory versus voluntary), although participants with psychosocial disability were slightly less likely to have a choice in which DES provider they accessed and were more likely to have been engaged with DES for longer. The majority of both groups had been employed in paid work at some point in their lives, with participants with psychosocial disability more likely to be currently working. Respondents with psychosocial disability were more likely to report experiencing insecure housing and homelessness. (See Table 5.5)

Qualitative interview participants were slightly younger than IDES respondents with a fairly even distribution across male and female participants when cohorts are combined, with one person identifying as gender non-binary. The majority of participants reported depression and/or anxiety as the main condition contributing to their disability, with others reporting psychosis and/or Post-Traumatic Stress Disorder. Many participants reported disrupted education, with a third not completing secondary school. Just over half engaged with DES as compulsory participants. At baseline, five interview participants were working part-time but were required or aspired to gain more hours, with two simultaneously studying; 20 were unemployed; four were volunteering but hoping to gain paid work with one also studying; and one person was solely studying. (See Table 5.5)

Of the 26 participants that completed the follow-up interview, four were in full-time paid employment; 10 were unemployed; three were volunteering but wanting paid employment; and eight were studying, two of whom were also working part-time, two volunteering, and, three looking for work. One participant had moved onto a parenting payment and was no longer engaged with DES or the labour market.

Whilst all participants in the qualitative interviews experienced significant vocational and non-vocational barriers to gaining and maintaining work, cohort two were experiencing more complex barriers to work at the time of interview. Overall, cohort one participants had a higher level of education and were more likely to have attained post-school qualifications when compared to cohort two. Cohort one participants were also more likely to report previous and current paid work.

Conversely, cohort two had lower levels of educational attainment and employment, were more likely to report more recent and ongoing housing insecurity, and, additional non-vocational barriers such as previous interactions with the justice system and substance misuse. Cohort one participants were however, more likely to report co-occurring physical conditions and/or impairments, be in receipt of the DSP and engaged with DES on a voluntary basis. (See Table 5.5).

Table 5.5 Baseline demographics

		IDES survey respondents			Qualitative respondents			Current DES population
		Psychosocial n (%)	Combined other n (%)	**Total n (%)**	Cohort 1 n (%)	Cohort 2 n (%)	**Total n (%)**	
Gender	Female	118 (66.7)	94 (49.0)	212 (57.5)	5 (35.7)	9 (56.3)	14 (46.7)	124,416 (46.8)
	Male	58 (32.8)	96 (50.0)	154 (41.7)	8 (57.1)	7 (43.8)	15 (50.0)	141,559 (53.2)
	Non-binary	1 (0.6)	2 (1.0)	3 (0.8)	1 (7.1)	-	1 (3.3)	NR
Age	18-24	21 (11.9)	24 (12.5)	45 (12.2)	3 (21.4)	1 (6.3)	4 (13.3)	39,084 (14.7)
	25-34	52 (29.4)	35 (18.2)	87 (23.6)	3 (21.4)	8 (50.0)	11 (36.7)	43,365 (16.3)
	35-49	60 (33.9)	46 (23.9)	106 (28.7)	8 (57.1)	6 (37.5)	14 (46.7)	73,490 (27.8)
	50 and over	44 (24.8)	84 (44.7)	126 (35.3)	-	1 (6.3)	1 (3.3)	109,736 (41.2)
Reporting other disabilities	Physical	38 (21.5)	15 (7.8)	53 (14.4)	5 (35.7)	1 (6.3)	6 (20.0)	NR
	Sensory	11 (6.2)	29 (15.1)	40 (10.8)	-	-	-	NR
	Psychosocial	-	88 (45.8)	94 (25.5)	-	-	-	NR
Highest level of schooling	< Primary school	2 (1.1)	1 (0.5)	3 (0.8)	-	-	-	NR
	Some high school <Y10	18 (10.2)	21 (11.0)	39 (10.6)	2 (14.3)	2 (12.5)	4 (13.3)	NR
	Year 10	33 (18.6)	46(24.0)	79 (21.4)	-	1 (6.3)	1 (3.3)	NR
	Year 11	27 (15.3)	37(19.3)	64 (17.3)	1 (7.1)	3 (18.8)	4 (13.3)	NR
	Year 12	96 (54.2)	86(44.8)	182 (49.3)	11 (78.6)	10 (62.5)	21 (70.0)	NR
Post-school qualifications	None	32 (18.1)	48(25.0)	80 (21.7)	6 (42.9)	10 (62.5)	16 (53.3)	NR
	Apprenticeship/ trade certificate	27 (15.3)	35(18.2)	62 (16.8)	1 (7.1)	1 (7.1)	2 (6.7)	NR
	Other certificate (I-IV)	55 (31.1)	62(32.3)	117 (31.7)	4 (28.3)	2 (12.5)	6 (20.0)	NR
	Associate degree/diploma	27 (15.3)	24(12.5)	51 (13.8)	1 (7.1)	-	1 (3.3)	NR
	University degree	35 (19.8)	21(11.0)	56 (15.2)	2 (14.3)	3 (18.8)	5 (16.7)	NR
Type of income support/ welfare benefit*	Newstart	131 (74.4)	142 (74.7)	273 (75.6)	6 (42.9)	13 (81.3)	19 (63.3)	202,059 (76.0)
	DSP	27 (15.34)	51 (26.6)	78 (21.2)	6 (42.9)	2 (12.5)	8 (26.7)	28,271 (10.6)
Engagement in DES	Compulsory	135 (76.3)	145 (76.7)	280(76.5)	6 (42.9)	11 (68.8)	17 (56.7)	206,155 (77.5)
	Voluntary	42 (23.7)	47 (23.3)	89 (23.5)	8 (57.1)	5 (31.2)	13 (43.3)	59,820 (22.5)
Choice in provider	Choice	64 (48.9)	74 (51.7)	138 (50.4)	5 (35.7)	6 (37.5)	11 (36.7)	NR
Length of time with current DES provider	12 months or more	86 (53.4)	74 (43.5)	160 (48.8)	4 (28.3)	3 (18.8)	7 (23.3)	NR
Employment history	Ever in paid employment	160 (90.4)	173 (90.1)	333 (90.3)	13 (92.9)	13 (81.3)	26 (86.7)	NR
	Currently in paid employment	54 (33.7)	43 (24.9)	97 (29.1)	4 (28.3)	1 (7.1)	5 (16.7)	NR
How main job was obtained	Applied after seeing advert	25 (46.3)	15 (34.9)	40 (41.2)	2 (40.0)	NR	NR	NR
	Through connections	5 (9.3)	8 (18.6)	13 (13.4)	-			

	of family/friends							
	Referred/ assisted by DES	15 (27.8)	12 (27.9)	27 (27.8)	2 (40.0)			
	Directly approached employer	8 (14.8)	4 (9.3)	12 (12.4)	1 (20.0)			
	Employer approached you	1 (1.9)	4 (9.3)	5 (5.2)	-			
Housing	Experienced insecure housing or no place to stay in last six months	25 (14.1)	18 (9.4)	43 (11.7)	3 (21.4)	5 (31.3)	8 (26.7)	20,126 (7.6)
Total		**177 (48.0)**	**192 (52.0)**	**369 (100)**	**14 (100)**	**16 (100)**	**30 (100)**	**265,975 (100)**

***** Welfare support in Australia includes various pensions and income support payments for people who are unemployed. Income support payments generally have mutual obligation requirements attached, i.e. recipients are obliged to actively look for work (compulsory job seeker status). Disability Support Pensions sometimes have compulsory requirements depending on age and assessed level of capacity. Newstart is the main form of income support for Australians of working age who are unemployed. Two qualitative participants were not receiving any income support, while one was on sickness benefits.

Chapter summary

Chapter Five outlined the aim of this study which was to explore the relationships between the life circumstances of DES participants with psychosocial disability and their engagement with the federal government funded DES program. A detailed description of the mixed methods approach utilised in the PhD, within the context of the broader IDES project, was followed by a discussion of the ethical considerations associated with this research. An overview of participant demographics was provided to help set the scene for the following chapters detailing the findings, beginning with Chapter Six which explores the life circumstances, and, barriers and enablers to employment experienced by qualitative interview participants.

Chapter Six: 'If I had stable housing I would be a bit more receptive to having a job.'

This chapter reports on the findings of the analysis of the 30 baseline qualitative interviews with DES participants with psychosocial disability. In doing so, the chapter responds to research questions 1-3 by examining the life circumstances, and, vocational and non-vocational barriers and enablers to employment experienced by participants. Constraints within and external to the DES system that make it more difficult for DES providers to address barriers to employment are presented. The chapter includes a paper accepted for publication in *WORK: A Journal of Prevention, Assessment, and Rehabilitation* (accepted 21 August 2019, due to be published in volume 65(4), April 2020).

If I had stable housing I would be a bit more receptive to having a job. **Factors influencing the effectiveness of Disability Employment Services reform.**

Authors: Alexandra Devine, Anne Kavanagh and Cathy Vaughan: Centre for Health Equity, Melbourne School of Population and Global Health, University of Melbourne, Australia

Abstract

Background: Continual reforms of the Australian Disability Employment Services (DES) Program aim to improve employment outcomes for people with disabilities, including people with psychosocial disability who experience high levels of unemployment.

Objective: To understand contextual factors in the lives of DES participants with psychosocial disability that influence their engagement with and potential benefits from the DES program in the context of the 2018 reforms.

Methods: Thematic analysis of 30 qualitative interviews with DES participants with psychosocial disability was conducted as part of the Improving Disability Employment Study between November 2017 to October 2018.

Results: Findings highlight diverse life challenges experienced by DES participants including disrupted education, inadequate access to mental and general health services, and financial and housing insecurity.

Conclusions: The life circumstances of DES participants with psychosocial disability are often complex, and, undermine their engagement with employment services and access to labour markets. Despite considerable investment in ongoing reforms, these circumstances continue to undermine the effectiveness of the DES program.

Key words: Psychosocial disability, employment services, work, social inequities

6.1 Introduction

The benefits of employment for people with disabilities are far reaching. Not only is the right to work a specific Article of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), but attaining this right facilitates the attainment of other rights, such as living independently with an adequate standard of living. At an individual level, employment can improve health and well-being, socio-economic conditions, and community and political participation (Bush et al., 2009; Milner et al., 2014; Mueser et al., 2016; Perkins, 2011; Simonsen et al., 2013; Strauser, 2013; UN General Assembly, 2006). At a population level, improving access to work for people with disabilities could significantly contribute to the economy of individuals, families, and countries (COAG, 2017; Deloitte Access Economics, 2011).

Of the approximately 18.3 per cent of Australians with disabilities, only 53.4 per cent of working aged individuals are currently in the labour force. This is compared to 83.2 per cent of Australians without disability. The unemployment rate for Australians with disabilities is 10 per cent, nearly double that of Australians without disability (5.3%) (ABS, 2016). Among people with disabilities in Australia, people with psychosocial disability have the lowest labour force participation rate (29%) and the highest unemployment rate (19%) (DSS, 2016b). These gaps in employment have remained stagnant for more than 20 years, despite the Australian Government's significant investment in and continual reform of their Disability Employment Services (DES) program.

In the lead up to the most recent July 2018 reforms, stakeholders called for significant changes to the DES program to improve sustainable and meaningful employment outcomes for people with disabilities (Australian Chamber of Commerce and Industry (ACCI), 2017; AFDO, 2014; DSS, 2015a; DSS, 2017a; Nevile, 2016). Proposed frameworks and recommendations for the DES reforms highlighted the need for greater investment in creating a system that enabled evidenced-based, individualized, integrated (e.g. employment and mental health services) and outcome-orientated employment services, particularly for those with psychosocial disability (Mellifont, 2017; Orygen National Centre of Excellence in Youth Mental Health, 2016). It was also recognised that more research is needed to understand broader contextual factors which may hinder the effectiveness of the DES reforms (Mellifont, 2017).

This study aims to examine the relationship between the life circumstances of people with psychosocial disability currently accessing the DES program, and, how their life circumstances are influenced by, or influence, their engagement with the DES program and their access to work. The

paper reports on findings from qualitative interviews with 30 people with psychosocial disability currently accessing the DES program on their perspectives on this nexus. In doing so, it highlights contextual factors which may undermine the effectiveness of current DES reforms, and contributes to the broader policy debate on addressing underlying structural barriers to employment for people with disabilities.

Access to the labour market for people with psychosocial disability

Psychosocial disability can be conceptualised as disability associated with a person's lived experience of mental illness. It is influenced by the interaction of a person's psychological condition, and, the socio-economic and cultural context in which they live. The level of disability a person may experience will depend not only on their psychological condition, but also on the barriers and enablers they experience when trying to live and participate in their communities (Drew et al., 2011; WNUSP, 2008). Not all people who experience mental illness will identify with or experience psychosocial disability, but it is widely recognised that people with mental illness and/or psychosocial disability experience significant barriers to gaining and maintaining work (Carroll et al., 2016; NMHCCF, 2011).

Increasing evidence highlights that social and economic inequalities, such as poor access to education and poverty, contribute to poor mental health (Lund et al., 2018). In turn, the socio-economic and health needs of people experiencing poor mental health are often inadequately addressed by a range of social policies and programs across their life course (McClelland & Smyth, 2014; Perkins, 2011). This compounds inequalities and can result in further social exclusion, poorer health outcomes, and unmet needs in relation to housing, drug and alcohol services, and, employment services (COAG, 2017; Harvey et al., 2016; Mithen et al., 2015; Morgan et al., 2012; Perkins, 2011). Barriers in addressing these needs have been attributed to both a lack of services, as well as the limited capacity of policies and programs to recognise and address the health and welfare needs of people with psychosocial disability. When these issues are not addressed, mental health conditions are often exacerbated, compounding barriers to employment (NMHCCF, 2011; Simonsen et al., 2013).

Like people with disabilities more broadly, people with psychosocial disability also experience systemic barriers to education and training, undermining access to work experience and career development. This is often coupled with community and workforce discrimination, including in recruitment processes, as well as limited awareness of programs that are available to support employers and employees develop and maintain disability-inclusive workplaces (ACCI, 2014; Paluch,

Fossey, & Harvey, 2012; Parletta & Waghorn, 2016; Simonsen et al., 2013). Further, broader structural barriers such as globalization and the flattening of labour markets have increased competition for fewer jobs across a number of sectors (e.g. manufacturing). Reports in Australia for example indicate there is only one job available for every eight people looking for work (Australian Council of Social Services (ACOSS), 2018). This particularly impacts on people with disabilities who may have fewer skills due to disrupted or poorer educational outcomes or work histories, and are often the first to be let go during redundancy processes (AHRC, 2016; DEEWR, 2014; National Disability Services, 2016; Strauser, 2013; Szymanski et al., 2012).

Reforming Australian Disability Employment Services

The DES program, which sits within the broader Australian social welfare system, is the federal government's specialised employment services program for people whose disability is assessed as their main barrier to gaining and maintaining employment (DSS, 2015b). This includes people with disabilities who receive government income support or the Disability Support Pension (DSP) who have been assessed as having the capacity to work for eight or more hours a week and are obligated under welfare compliance measures to engage in the DES program (DSS, 2013). Tightening eligibility for the DSP has seen growing numbers of people with disabilities referred into the DES program, which currently has just under 200 000 current participants, 38.3 per cent of whom are categorised as having a 'psychiatric disability' (DSS, 2020).

Research on the effectiveness of employment services for people with psychosocial disability within the Australian DES context predominantly focuses on the need to improve the skills and qualifications of the DES workforce (Buys, Matthews, & Randall, 2015; Byrnes & Lawn, 2013; J. King & Waghorn, 2018; Rampton, Waghorn, De Souza, & Lloyd, 2010); intrinsic traits and behaviours of job seekers (Matthews et al., 2014); and, the need for and challenges to implementing evidenced-based practices. This includes the practice of Individual Placement and Support (IPS), widely recognised as the most effective employment intervention for people with psychosocial disability (Parletta, 2015; Sherring et al., 2010; Suijkerbuijk et al., 2017; Waghorn et al., 2007; Waghorn et al., 2014; Waghorn & Hielscher, 2015). IPS has been implemented widely across the USA and is commonly cited as the most appropriate evidence-based practice to support people with mental illness to access employment. Included among the eight key principles of IPS is the co-location of mental health and employment services, and, the rapid placement of job seekers into employment. The evidence from the literature suggests that for IPS to be effective, high fidelity with all eight principles is required. Challenges in the Australian context include the difficulty of implementing key criteria of the IPS model, such as integration of mental health and employment services, when they

function under separate funding and contractual arrangements (R. King et al., 2006; Morris et al., 2014; Parletta, 2015; Waghorn et al., 2007; Waghorn & Hielscher, 2015).

Perspectives of DES participants with psychosocial disability are less readily available in the literature. What has been done, highlights work can have both positive (e.g. improved self-esteem, decreased financial insecurity) and negative effects (e.g. compounding stress and health conditions, experiences of discrimination) on mental health (Gladman & Waghorn, 2016). Length of unemployment has been reported by employment services participants with mental illness as a significant barrier to work (Harris, Matthews, Penrose-Wall, Alam, & Jaworski, 2014). More broadly, DES participants (not just those with psychosocial disability) have reported the impact of negative treatment within the program, citing a need for services to better respect their circumstances and work aspirations (AFDO, 2014; Nevile & Lohmann, 2011).

Funding models for employment services prior to the 2018 reforms were criticised for creating disincentives to the provision of individualised support, preventing services from addressing the vocational and non-vocational barriers to work experienced by many participants (Nevile & Lohmann, 2011; Perkins, 2011). This is significant given many participants of the program experience challenging life circumstances which can complicate access to work. For example, approximately 18 per cent of participants referred into DES are from non-English speaking backgrounds; 6.4 per cent have previously been incarcerated; 6.3 per cent are homeless; and 3.6 per cent are from a refugee background (DSS, 2020).

The introduction of a new 'risk adjusted funding model' under the reforms, recognises that some DES participants require more support than others to gain and maintain employment. Along with an increase in outcomes based funding, this model is intended to incentivise DES providers to support harder to place participants to gain and maintain more sustainable employment (DSS, 2017a). Other changes outlined in the reforms include improving choice and control for participants through increasing competition between providers within the DES market, by allowing more providers to enter the market, and, stopping the process whereby each provider is referred a known quota of participants (i.e. this ensured a steady flow of income they did not have to compete to attract for); allowing participants to choose which DES provider they access and to change providers if they are dissatisfied with the service provided; and, allowing some flexibility in how meetings between participants and DES providers are conducted as part of mutual obligation requirements (DSS, 2017a).

It is difficult to know at this stage if these recent reforms will enable the DES program to deliver evidenced-based approaches, such as integrating mental health and employment services, and strengths-based, outcome orientated approach to service delivery (Mellifont, 2017). As highlighted by Mellifont however, even if these changes do occur, there needs to be a greater understanding of the external factors which may continue to undermine the effectiveness of the DES program (Mellifont, 2017). This is particularly so for people with psychosocial disability that continue to experience unacceptable exclusion from the labour market.

6.2 Methods

The Improving Disability Employment Study (IDES) is a project conducted by the University of Melbourne, in partnership with disability and employment provider peak bodies, employment service providers, and disability advocacy bodies. The overall aim of IDES is to improve understanding of factors that promote sustainable and meaningful employment outcomes for people with disabilities. IDES involves a) a prospective cohort quantitative survey of 369 adults with disabilities currently accessing mainstream employment services and DES providers, and, b) as well as this nested qualitative study that aimed to better understand the life circumstances of people with psychosocial disability currently accessing the DES program.

Recruitment

Two methods of recruitment were utilized: 1) 8 people were recruited through the IDES survey (including piloting) of 369 participants conducted between February 2018 and December 2018, and, 2) 22 people were recruited directly through DES providers. Potential participants for the qualitative interviews included IDES survey respondents who: 1) had given prior consent to be contacted for follow-up interviews, and 2) had been identified by DES providers and through self-report within the survey as having a psychosocial disability. Eligible potential participants were contacted by the lead author (AD) and provided with information about the qualitative interviews. If potential participants confirmed their interest in participating, a time and meeting place was arranged to conduct the interview.

The research team also worked with four DES providers who specifically work with participants with mental health conditions to recruit participants. DES frontline staff interact with participants with psychosocial disability on a daily basis. These interactions provided the opportunity for frontline staff to provide participants with information about the qualitative study in the form of a

flyer and Plain Language Statement. Interested participants were followed up by the lead researcher (AD). All participants were 18 years or over.

Data collection

Participants partook in a face-to-face, semi-structured interview between November 2017 and October 2018. Participants were asked about their lives including their physical and mental health; the relationship between work and their mental health; previous and current experiences of work; and, about their engagement with the DES program. The participants had the opportunity to participate in the interview with a support person if they wanted to, although all participants chose to participate on their own. The interview times were approximately 30-45 minutes. Informed consent was collected from all participants prior to the interview.

Data analysis

Audio-recordings of the interviews were transcribed by AD. All transcripts were then initially deductively reviewed drawing on the research objectives and literature on work, disability and DES. An inductive process was then utilised to identify further codes emerging from the data. A thematic coding framework was then developed based on this inductive analysis and the research objectives. Data was then re-analysed using a thematic approach to analysis as described by Braun and Clarke (2006) (Ritchie et al., 2013). The qualitative analysis software NVivo was used to organise the data and support this process.

Ethics

Ethics approval for the IDES project and the nested qualitative study were obtained from the University of Melbourne's Human Research Ethics Committee (ID 1545810.1 & 1750133.1).

6.3 Results

Demographics of participants

Participants interviewed were between 21 and 57 years of age. The cohort was a mixture of participants whose income support mutual obligations required them to engage with DES providers to actively find work; DSP and sickness allowance recipients not under obligation but voluntarily seeking the services of DES providers to support them to find work; and two participants not

receiving income support but also voluntarily seeking the support of the DES program. Of the 30 participants, five were currently working part time, but were required or aspired to gain more hours, 22 were unemployed, and three were volunteering, but hoping to gain paid employment. (See Table 6.1)

Table 6.1 Participant demographics

Variable		
Age in years	Average (range)	36.5 years (21-57yrs)
Gender	Male	n(%) 15 (50.0)
	Female	14 46.7)
	Gender non-binary	1 (3.3)
Country of birth	Australia	28 (93.3)
	Other	2 (6.7)
Geographic location	Urban/Semi-urban	19 (63.3)
	Regional/Rural	11 (36.7)
Highest level of schooling	< Primary school	0 (0.0)
	Some high school <Y10	4 (13.3)
	Year 10	1 (3.3)
	Year 11	4 (13.3)
	Year 12	21 (70)
Post-school qualifications	None	16 (53.3)
	Apprenticeship/ trade certificate	2 (6.7)
	Other certificate (I-IV)	6 (20.0)
	Associate degree/diploma	1 (3.3)
	University degree	5 (16.7)
Self-reported main mental health condition	Depression and/or Anxiety	24 (80.0)
	Post-Traumatic Stress Disorder	2 (6.7)
	Schizophrenia/Psychosis	4 (13.3)
Welfare Support*	Disability Support Pension	8 (26.7)
	Newstart Allowance	19 (63.3)
	Sickness Allowance	1 (3.3)
	No income support	2 (6.7)
DES engagement	Voluntary	13 (43.3)
	Compulsory	17 (56.7)
Employment status	Unemployed & not volunteering	22 (73.3)
	Volunteering & not in paid work	3 (10.0)
	Working part time but needing/wanting more hours	5 (16.7)
	Full-time	0 (0.0)

* Welfare support in Australia includes various pensions and income support payments for people who are unemployed. Income support payments (such as Newstart allowance) generally have mutual obligation requirements attached, i.e. recipients are obliged to actively look for work (compulsory job seeker status). Disability Support Pensions sometimes have compulsory requirements depending on aged and assessed level of capacity.

Life circumstances, access to work, and, the DES program

> *[Work] is something I've always wanted. To just give me a sense of acknowledgement from the world. Like the world wants my skills, the world wants to pay me money. But even if it's a volunteer job, I just want to be useful … and I want to be a good mum to my daughter.* (Participant #3, P3)

All participants expressed a desire to work and felt that finding work would improve their socio-economic conditions and mental health. Despite this, the majority of participants reported a number of challenging life circumstances which impacted on their capability to gain and maintain employment. As described below, for some participants, the emergence of their mental health condition during adolescence contributed to difficult life circumstances (e.g. disrupted education) that undermined access to work. For others, traumatic life experiences (e.g. sexual violence, military service), were reported as contributors to or triggers of their mental health conditions which in turn impacted on their employment, and subsequently influenced their life circumstances.

Participants' expectations of the capacity of DES providers to address life circumstances that undermined their access to work varied. Individuals that had been in the system for longer or with more substantial barriers expressed concern that the DES program was not equipped to help them overcome their barriers to work. Individuals more recently entering the DES program were more optimistic of the capacity of DES providers to support their access to work.

> *I cannot compete on the same level as someone searching on Seek* [online job search platform]. *Because of lack of experience. I have been out of the workforce for quite a while. Plus maybe my mental illness may hinder this process. However I thought to myself there must be an agency that caters for people like me … At the moment I am quite happy to be here because they are pretty much around-the-clock. I know, sure, they're an organisation that needs to make money. I understand that. However, they are the only ones that put their hat in the ring and said yes we will give it a go. We will go in to bat for you and they are a making concerted effort to do so.* (P15)

Education

> *I didn't finish year seven, because my mother was crazy. I don't mean that lightly. She kept me home and kept it from the family, and I was busy looking after her or doing things for her. And so that was sort of six years of hiding before the family found out that I didn't go to school.* (P10)

Whilst a number of participants had completed secondary education and gone on to complete post-secondary qualifications, more than half of the participants described experiencing difficulties during their schooling. These included disruptions in education due to their own or family members' mental health conditions, and, inadequate support to remain engaged in school. Experiences of bullying were reported to contribute to low self-esteem, anxiety and depression, and in some instances, withdrawal from education.

> *So I think I was only diagnosed with anxiety and depression three years ago. But I look back at what I was going through at high school and I definitely had it back then … They were just horrible the kids at school … I reckon that has a lot to do with now my self-confidence, my self-esteem, anxiety … I couldn't get away from it and anywhere I was, so I was stuck with being bullied. Just my whole childhood really.* (P5)

Limited processes within the education system to support participants with specific learning disabilities such as dyslexia, also prevented individuals from completing their education or following the educational path they had envisaged for themselves. A number of participants also described challenges transitioning between school to post-school education and training, as well as limited support to transition into subsequent employment.

> *Once I got to high school it was just really hard, because of my dyslexia, the school didn't really want to help me with it. They were just really worried about their grade point average. So they were trying everything just to try and kick me out. And it got to the point where mum was sick of them bullying me and said we will bring you in here* [regional town]. (P6)

Developing knowledge and skills was seen as vital to future access to work, particularly for those whose prior education had been disrupted. Participants however described various barriers to pursuing education and training, with mixed support from their DES provider to overcome these barriers. Some participants were eligible for State government financial support to access certain courses. For others, the cost of fees and required resources was prohibitive, with participants reporting discrepancies between and within DES providers about who and what got funded in relation to ongoing education.

> *And I have asked for help with training to pay my fees, buying my books or something … like twice I had approached* [regional Technical and Further Education Institute] *to do Community Services but I wasn't getting any support here* [DES provider]*. And I can't afford to do that and buy all the books. And you know, like I wanted to do the Diploma but I was willing to do the Certificate 3 to get in, to get started. But I'm just not getting the funding …*

> *the most they have provided for me is three fuel vouchers and I know other providers are providing more than that.* (P24)

Educational aspirations were also discouraged by some DES providers. Negative assumptions about participants' capacity to pursue their preferred educational pathway not only undermined mental health but in some cases led participants to access courses that they were not interested in or did not support their future career aspirations.

> [Employment consultant] *reckons that I can't do the Uni thing.* [I]: Why is that? [P]: *She goes 'I just don't reckon you are going to be able to handle it at the moment' … I kind of felt a bit upset when she said it. I didn't cry or anything, but sort of felt a little bit like I thought, I think, I can do it. And I've done Uni before. I did it full-time and I know I ended up having depression and that, but I am on current medication that I am not going to stop taking and it is the best medication that I've ever had.* (P25)

Traumatic life events

> *Essentially I lost my job not long after my divorce. So that was a combination of the difficulties I was experiencing. I had severe depression around the time of separation due to family law issues, and that caused and created difficulties at my job, and just engaging in my job.* (P9)

The overwhelming majority of participants reported challenging or traumatic life events that significantly influenced their mental health, engagement with work, and broader life circumstances. This included difficult upbringings and ongoing complex relationships with family; migration to Australia after living in conflict areas; experiences of violence and abuse, including within community disability housing; accidents and injuries; homelessness and hospitalisation associated with poor mental health and suicide attempts; and, post-traumatic stress related to military deployment.

> *I had my first full time job when I finished Uni … It was a pretty full on job. I had been recently diagnosed with PTSD after severe sexual assaults and other things in my early 20s … I had all that disaster just as I was finishing my degree. I was very passionate when I first started social work about helping people … but I felt like I couldn't tell people things would be ok after my experiences.* (P1)

Whilst some participants were supported to try and access external mental health support, overall, participants did not feel that DES staff have the appropriate skills to support the mental health needs of participants, particularly for those who have experienced trauma. Limited skills in understanding how previous traumas may influence barriers to work, were also thought to limit the

capacity of DES staff to determine how best to provide support to participants and not contribute to further trauma.

> *What is really missing is some attending skills, like listening to clients. And you know you don't have to be a counsellor because there are mental health services for people, but listening and understanding that I am telling you what you want to hear, not what I'm feeling. You know? The perception is not there, that is an issue.* (P24)

Some DES providers provide internal training sessions to support job seekers develop positive thinking and resilience strategies. Many participants found these sessions beneficial, especially when they were offered alongside other sessions on identifying skills and aspirations, resume writing, or effective job searching. There were, however, participants that felt a focus on individual level topics such as resilience over-focused or inadvertently blamed the individual for their unemployment, and how such a focus ignored the limited availability of jobs and the broader barriers experienced by people with disabilities trying to access the labour market.

> *So these platitudes you have to be more resilient and all this and that, and we sit out there and* [employment consultant] *tells us everything we are doing wrong, and people sit there and agree and soak up all this narrative that it's our fault. And it gets to me … I dunno, if you were to improve a place like this as far as I'm concerned, it would have plastered on the wall, 'It's cool', 'It's not your fault this country is so messed up right now', 'Let's try and fix the country'. But that's completely antithetical to and sort of lends itself to pop psychology. Like this resilience thing. There might be something to it but I'm not sure.* (P21)

Co-occurring mental and physical health conditions

> *I have permanent nerve damage in my hands from doing hairdressing … All the things that I love and I'm really good at have to do with my hands. So whilst I had done a lot of work on my depression and prior to this happening I was a pretty functional active member of society … certainly not been able to use my hands the same way has definitely impacted on my mental health again.* (P19)

Just under half of the participants reported co-occurring physical health conditions (e.g. HIV, injuries, and neurological conditions). These participants discussed the challenges of trying to manage physical and mental health conditions whilst trying to look for work. Participants also reported their physical health conditions not only negatively impacted on their mental health, but precluded them from certain types of employment and career aspirations that they may otherwise have been able to pursue.

> *While I was doing* [previous job] *I would go to an osteopath every week and have it* [back] *adjusted. But now that I'm not working I can't afford to do that. So I just kind of put up with it. It's not great.* [I]: And how does that impact on your mental health? [P]: *It's not great because I think about it all the time, especially when I'm looking for jobs, because I think I couldn't do that, I couldn't stand up to do that job, or that would be challenging for me, so I think about it all the time.* (P7)

Some participants reported very good access to services and supports. However a number of participants reported not being able to access as much support as they would like, often due to financial hardship, and insufficient government funding to access mental and allied health services. Even if DES providers attempted to refer participants to services, limited availability of services was also reported.

> *I have got a psychologist in Melbourne but I have run out of the mental health plan[11], and I can't afford a normal psychologist. … She* [employment consultant] *tried to get me linked in with the mental health support here, but they wouldn't have anything to do with me because I wasn't on Ice* [crystal methamphetamine] *… Most of their funding is focused on the Ice epidemic.* (P10)

Addressing physical and mental health conditions was recognised as often being beyond the skills and resources available to frontline workers. However, participants highlighted the importance of workers having a greater understanding of how these conditions impact on access to work. Participants therefore appreciated when staff helped them identify alternative employment pathways. The DES program was also consistently acknowledged as providing more support than the equivalent mainstream program *jobactive*.

> [Previous mainstream provider] *just didn't care. They just wouldn't support you in any way. I think the only time they suggested a job to me, somebody was like 'there is a job down at Plaza at the Asian food shop there, just go and hand in your resume right now. It's full-time.' I said well that's all well and good but I am dyslexic and I find it hard to understand other people's language sometimes … and with my anxiety, it makes me really stressed out …* [Current DES provider] *have taken a different approach. Like so far we have done something that really helped me. Sort of like a computer thing that tells you what careers would be*

[11] The federal government provides some funding for eligible individuals to attend psychology services for six to ten visits per year. There is, however, often a payment gap between what is charged and what is funded. Ten sessions is also not necessarily sufficient for a number of people with psychosocial disability.

good for you and it pretty much says that I am a people person, so a job that is caring for other people would be really good. (P6)

Financial and housing insecurity

The housing is a big issue for me currently and people are really pulling their resources to try and get me housing. Even my ex is going to inspections for me and everything so it's all good. They realise [mental health team] *if I had stable housing, I would be a bit more receptive to having a job and I'd be more likely to attend work.* (P3)

The majority of participants reported experiencing persistent financial hardship. This was related to a variety of factors including unemployment; and, the low rate of the DSP and other income support payments that are not sufficient to meet basic needs, disability and health related expenses, or to ensure a decent quality of life for themselves and their dependents. This in turn was reported to have a negative impact on mental health; made it more difficult to look for or engage in work due to associated costs (e.g. travel for job searching, clothing for interviews) or pursue employment pathways (e.g. further study); compounded debt; and, limited participants' control over their broader life circumstances. As noted above, the financial support DES provides in terms of pursuing study or costs associated with job searching (e.g. vouchers for travel) is limited and not consistent across the program.

We can't get well unless we are financially [secure]. *It's all just really hard. I'd much prefer just to have some consistency, even to know where I was living so I could know where to look for work if that makes sense.* (P1)

Housing insecurity was a significant issue for approximately half of the participants. Work was therefore highlighted as crucial to supporting access to housing. Conversely, housing security was seen as a key requirement enabling participants to look for work. Further, access to secure, affordable and safe housing was reported to be a major barrier to physical and mental health. A third of participants were currently living with family, yet generally expressed a desire to live independently if they could afford to.

I always had a problem with my father. He is a bit abusive at times. So that is something I had to deal with. … It is crazy but because of my situation I still have to live at home … I can't support myself yet so this is the only option. (P13)

A few participants were benefitting from government and non-government housing services, yet others reported being waitlisted for housing for more than a decade, despite attempts by DES providers to support referral processes into various housing services. In the interim, some

participants had been exposed to life threatening experiences while living in emergency or short-term accommodation services.

> *I have been pretty much in the homeless category for the last five years, as in no consistent accommodation … all of that has a huge impact on work. So in February 2016 I was working in* [suburb of Melbourne], *I was living in* [another suburb of Melbourne] *in* [short term accommodation service for women]*. I came home from work one night, went to my room, I could hear the screaming and yelling … A woman was murdered in the kitchen. And I was expected to go to work the next day as a care supervisor for elderly people. You know, it's too much. I didn't feel safe. I never felt safe. Having routines and systems that work for you and when you have a mental health condition, for me, the more systematic I can be the better.* (P1)

Engagement with the labour market

Employment history varied considerably across the cohort. Whilst only five participants reported they had never had paid employment, more than two thirds were currently unemployed. One quarter of the participants were currently or previously engaged in some form of volunteer work. Participants reported this provided them the opportunity to develop confidence and skills useful for transitioning into paid employment, as well as a sense of social inclusion.

For participants that were currently working, the majority reported not being able to gain as many hours of work as they would like, or were in roles that undermined their mental health. All participants described previous or current stressful or precarious work conditions. This included underpayment, even when a government funded wage subsidy was concurrently being claimed by the employer; bullying within the workplace; and, unrealistic employer expectations in regards to job roles.

> *I think there is a lot of dodgy employment out there. I recently tried out in a cleaning job. I probably did about 30 hours for them and they only paid me for 18 and their justification was my work wasn't good enough.* (P1)

Participants also described examples of employment services (mainstream services and DES) and employers undermining their capacity, or pushing participants into inappropriate or precarious jobs. Participants reported that these experiences within the labour force and in engagement with DES providers caused significant distress and undermined their confidence that the employment services could help them gain and maintain meaningful work.

> *When I first went to* [previous DES provider] *I presented with my qualifications … and the young women I was working with, that didn't last. She told me I was hitting too high and I was possibly too psychologically damaged to follow the profession of social work and I should be looking for something else and I found that really devastating.* (P1)

A major concern highlighted was in relation to the limited jobs available in comparison to the number of people looking for work. Participants felt particularly disadvantaged in these circumstances due to their mental health and/or disability, and their limited work experience.

> *I just guess that on paper it just looks like I've had a whole bunch of voluntary things and people wonder why I can't be employed for pay… So I think people just don't give me a chance. I've written cover letters explaining what is going on and to give me a chance … I think that on paper the people get scared. They don't understand disability in general and they don't want to know, all that is so much effort, let's go with the easy person that didn't have a disability rather than the person who is disabled.* (P3)

Compounding disability-related discrimination creating barriers to work, participants reported experiencing discrimination related to being unemployed and receiving income support and the negative impact this had on their mental health.

> *Yeah I do* [enjoy working]. *Because I feel more confident, and much better as a person about myself. And I don't feel like people judge you so much … The first thing people say is 'what do you do?' And if you don't do anything, people are just very judgmental and kind of assume you are a bum or an idiot. I just don't like feeling like nothing. So I prefer to be working, even if it's part-time. It's not my fault if I can't handle full-time work, I still feel better to say I do something.* (P17)

Participants expressed alternative perspectives to the negative rhetoric and discrimination towards welfare and unemployment that they frequently experienced within and external to DES. This perspective advocated for a greater focus on job creation.

> *Rather than spending a couple of billion dollars a year yelling at people and getting people to out grovel each other, if there was guaranteed employment … It's up to them to find something meaningful for people to do. Rather than say that there is nothing there for 5 per cent of society, therefore it is that 5 per cent of the population's fault. If there is nothing for that 5 per cent of the population to do, therefore we had better think of something.* (P21)

6.4 Discussion

Recognising the limitations of this study to the extent that the relatively small sample was drawn from a limited number of DES providers and therefore may not represent the life experiences of all DES participants with psychosocial disability or the models of practice delivered by alternative DES providers, this study nonetheless reiterates the need for the DES reforms to better enable evidence-based, individualized, integrated and outcome-orientated employment services (AFDO, 2014; Mellifont, 2017; Waghorn & Hielscher, 2015). Looking for work in the context of limited jobs, and, persistent disability and welfare related discrimination, can negatively impact on the mental health of job seekers (AHRC, 2016; Schofield & Butterworth, 2018). Better integration of mental health and employment services, as implemented through IPS models, would enhance the capacity of DES providers to support people with psychosocial disability to cope with the stresses of finding work articulated by the study's participants. Ideally, it would also ensure services identify and support the career aspirations of participants, as this study highlights ongoing disparities between participants in relation to the level of support they have experienced to pursue their work goals (AFDO, 2014; Nevile, 2016).

DES commentators have also called for understanding of external factors which may influence effectiveness of the DES program (Mellifont, 2017; Nevile & Lohmann, 2011). This study highlights that even if the DES reforms enable better integration of mental health and employment services, this alone will not improve the effectiveness of the program. All participants interviewed described challenging life circumstances that undermined their mental and physical health, and created significant barriers to gaining and maintaining work. Key challenges included disrupted education, traumatic life events, inadequate access to mental and general health services, and financial and housing insecurity. As highlighted by these participants however, the DES program remains inadequately resourced and incapable of addressing entrenched non-vocational barriers to employment.

This study also contributes to the growing international evidence demonstrating the important relationship between socio-economic factors, mental health, and work (Kavanagh et al., 2016; Kavanagh et al., 2015; Lund et al., 2018; Mithen et al., 2015). Social inequalities which create barriers to education, housing, and financial security, contribute to poor mental health. If barriers are inadequately addressed, it is more difficult for individuals experiencing poor mental health and difficult life circumstances to access the support they require to enable their recovery. In essence,

social inequalities and the inability of social policies and programs (e.g. education, housing, employment) to ensure the health and welfare of people with mental illness create a disabling environment. This is particularly relevant to engagement with and benefit from the DES program and broader labour markets. Until we adequately address this cycle and more effectively address non-vocational barriers to work, we cannot expect people with disabilities to benefit as much as they should from the DES reforms.

Nonetheless, the DES reforms provides a critical opportunity for the government, DES providers and broader health and social services, to listen to the perspectives of people with psychosocial disability and ensure that the design and implementation of models of services are integrated, with improved support across other sectors to help concurrently address the vocational and non-vocational barriers to gaining and maintaining work (Lawson, Pawson, Troy, van den Nouwelant, & Hamilton, 2018). This requires broader social policy changes in Australia to address social inequalities and reduce the likelihood that people experience psychosocial disability, but, are better supported if they do.

Existing evidence from the Australian context, and the experiences of this study's participants emphasises the need for broader policy reforms to focus on improving access to mental health and social services; addressing the lack of affordable and accessible housing; addressing the level of financial hardship and poverty experienced by people with disabilities and income support recipients; improving educational outcomes and transition processes for people with psychosocial disability; and, increasing the availability of employment opportunities that meet the diverse needs and aspirations of people with disabilities (ACOSS, 2018; COAG, 2017; Deloitte Access Economics, 2018; Lawson et al., 2018; NMHCCF, 2011; Productivity Commission, 2018; Trajkovic, 2008). Enhancing integration of mental health and employment services is an obvious recommendation. Extending this to integrate broader social services (e.g. housing) should also be considered. Not only will this start to address underlying barriers to employment and improve the capability of participants to engage with the labour market, but it is also likely to benefit DES providers, who rely on placing job seekers in employment for their revenue.

6.5 Conclusion

The life circumstances of DES participants with psychosocial disability are often complex, and undermine their engagement with employment services and access to labour markets. Despite considerable investment in ongoing reforms, these circumstances continue to undermine the effectiveness of the DES program. It is important that service providers and policy makers document and understand these complexities. However, without greater efforts to address these systematic

barriers to employment across all policy sectors, people with psychosocial disability will continue to experience social inequalities and unjustified barriers to the labour market that the DES program alone is not resourced or capable of overcoming. Ultimately, this undermines the right of people with disabilities to work, making it more difficult for them to attain, enjoy and benefit from all other rights. Models of evidence-based service delivery that better integrate mental health and employment services are most definitely needed in the Australian context. It is time however, to develop approaches which better integrate broader policies and services to actually address external factors which undermine the DES program and access to work for people with psychosocial disability.

Chapter summary

This chapter platforms the challenging life circumstances often experienced by DES participants with psychosocial disability which hinder their capacity to gain and maintain employment. The chapter further highlights the constraints within and external to the DES system that undermines the capacity of DES providers to implement effective, evidence-based and integrated practice to address the complex employment barriers experienced by DES participants. The following chapter explores how different policies intersect with individual and contextual factors to further influence life circumstances of DES participants, and, the effectiveness of the DES program.

Chapter Seven: How disability and welfare policies interact to influence the right to work of people with psychosocial disability.

This chapter presents an analysis of IDES Wave 1 quantitative survey data, and, the 56 qualitative interviews (30 baseline and 26 follow-up). The analysis was undertaken to explore how individual and contextual factors intersect across policies to further influence life circumstances of DES participants, and, the effectiveness of the DES program. The analysis focuses on the interaction between the National Disability Insurance Scheme (NDIS) and DES and continues to extrapolate on findings relevant to RQ1-3. The chapter is comprised of a paper accepted as conference proceedings and presented at the Fourth International Conference on Public Policy, held in Montréal in June 2019, in the panel entitled: Public Policy Approaches to Protecting and Enhancing the Rights of Persons with Disabilities. The panel aimed to examine whether and how existing policy approaches facilitate or hinder the equal rights of minority and other marginalized populations directly or indirectly, and was chaired by researchers from the WORLD Policy Analysis Centre at the University of California Los Angeles (UCLA).

How disability and welfare policies interact to influence the right to work of people with psychosocial disability.

Authors: Alexandra Devine, Cathy Vaughan, Sean Byars, Anne Kavanagh, Centre for Health Equity, Melbourne School of Population and Global Health, University of Melbourne, Australia

Abstract: Australians with psychosocial disability often experience socio-economic inequalities, poor health, and multiple challenges accessing services, all of which are causes and consequences of poorer employment outcomes. Australia has seen unprecedented changes in public policy relevant to the rights of people with disabilities, specifically with the introduction of the National Disability Insurance Scheme (NDIS). Achieving the NDIS's objective of improving employment outcomes for people with disabilities is influenced by the federal government's Disability Employment Services (DES) program. Both the NDIS and DES are implemented through New Public Management mechanisms, encouraging consumer choice and control to stimulate competition in the marketization of these programs. This paper explores how the implementation, resourcing and interaction of these policies are impacting on the lives of people with psychosocial disability and their subsequent right to work. The paper draws on the Improving Disability Employment Study (IDES) - a quantitative survey of 369 people with disabilities currently accessing employment

services, as well as findings from 56 qualitative interviews with DES participants with psychosocial disability.

Key words: Psychosocial disability, New Public Management, choice and control, employment

7.1 Introduction

Psychosocial disability can be conceptualised as disability associated with a person's lived experience of mental illness. It is influenced by the interaction of a person's psychological state (e.g. different ways of processing, interacting, and experiencing situations) and the context in which they live (NMHCCF, Drew et al., 2011; 2011). Not all those with mental illness experience psychosocial disability. However the discrimination and exclusion all too often experienced by people with mental illness across numerous life domains can contribute to disabling contexts. Similarly, people with psychosocial disability often experience significant socio-economic inequalities and poorer health outcomes when compared to people without disability. These factors are both causes and consequences of poorer employment outcomes (Harvey et al., 2016; Kavanagh et al., 2015; Morgan et al., 2012). In many contexts they also contribute to the situation where people with psychosocial disability are recognised as a marginalised group who have experienced substantial violations of their human rights (Carroll et al., 2016; Drew et al., 2011).

The United Nations Convention of the Rights of Persons with Disabilities (UNCRPD) was the first comprehensive platform by which to analyse the barriers and enablers to the attainment of rights of people with psychosocial disability (Drew et al., 2011; Harpur, 2012; Kayess & French, 2008). Article 3. of the UNCRPD highlights that individual autonomy is a fundamental requirement for people with disabilities to attain their human rights (UN General Assembly, 2006, p. 3). Indeed, extensive literature supports that choice and control in one's life promotes well-being, social functioning and quality of life (Patterson et al., 2016; Shanks et al., 2013). Having a sense of choice and control has also been shown to be important in a person's career development, thus influencing Article 27. of the UNCRPD on the right of people with disabilities to work (Eklund, 2007; Simonsen et al., 2013).

Since Australia's ratification of the UNCRPD in 2008, the national policy context has seen a growing emphasis on promoting the rights of people with disabilities. This is perhaps most evident in the roll-out of the NDIS. The NDIS aims to place people with disabilities at the centre of decision-making around what and how services and supports are purchased across their lifetime, through individualised budgets to achieve self-determined goals. This includes attaining the right to work. Moreover, the budgetary implications of the scheme were rationalised on modelling that the NDIS

would lead to increased employment outcomes for people with disabilities and their carers, thereby offsetting the cost of implementation (Productivity Commission, 2011).

Yet Australians with disabilities continue to be excluded from the labour market, with Australians with psychosocial disability reported to have the lowest labour market participation rates (29%, vs. 53.4% for people with other disabilities and 83.2% of people without disability), and the highest unemployment rate (19%, vs. 10% for people with other disabilities and 5% for people without disability) (ABS, 2016; DSS, 2016b). This is despite significant investment in Australia's Disability Employment Services (DES) - the federal Government's specialised welfare program for people whose disability is assessed as their main barrier to employment (DSS, 2015b). DES providers are contracted by the federal Department of Social Services (DSS) to support and monitor the efforts of people with disabilities in receipt of income support (and a small number of voluntary participants) to actively promote their employability and participation in the labour market (DSS, 2016b).

Both the NDIS and DES programs have been part of a shift in how disability and welfare policies are implemented in Australia, influenced by ideas associated with a New Public Management (NPM) philosophy. Whilst the NDIS and DES markets are distinctly different, this shift has seen a transition away from publicly-funded and delivered disability and welfare services to the quasi-marketization of services provided by for-profit and non-profit businesses, and in the case of the NDIS, some government managed services (Considine et al., 2018; Hood, 1995; Marston et al., 2016; Needham & Dickinson, 2018).

Much of the inspiration for the NPM philosophy was derived from private consumer market theories which assume choices are made in isolation, with limited consideration of the complex circumstances which often influence the decision-making capabilities of individuals in need of welfare services (Clarke et al., 2005; Glendinning, 2008). Yet capability for exercising choice and control is influenced by a multitude of dynamics including socio-economic conditions and availability of support and resources to nurture independence in decision-making (Arstein-Kerslake, 2017; Collyer, Willis, Franklin, Harley, & Short, 2015; J. Jenkinson, 1993). How the opportunity for choice and control is exercised in one program may influence outcomes in another and may also be influenced by the broader policy and socio-economic context.

This paper draws on findings from the Improving Disability Employment Study (IDES) - a quantitative survey of 369 people with disabilities currently accessing employment services, alongside 56 qualitative interviews with 30 DES participants with psychosocial disability. The analysis aimed to identify how the implementation, resourcing and interaction of the NDIS and DES influences access

to work for people with psychosocial disability. This research highlights that the effectiveness of these programs is hindered by challenges occurring within each program and at their interface, as well as the persistent barriers to employment encountered by people with psychosocial disability in the wider social and policy contexts in which they live.

People with psychosocial disability at the intersection of disability and welfare reforms

The philosophy and discourse underpinning the NDIS intertwines the notion of choice and control as conceptualised within the disability-rights movement, with that of NPM inspired mechanisms which aim to promote consumer choice to stimulate the marketization of services made available to people with disabilities (Bonyhady, 2014; Chesterman, 2015; Marston et al., 2016; Purcal et al., 2014). Administered by the National Disability Insurance Agency (NDIA) under the NDIA Act 2013, with government oversight from the Minister for Families and Social Services and the DSS, the NDIS was initiated in seven trial sites across Australia between July 2013 and July 2014, with full roll-out beginning in July 2016. When fully implemented, it is expected to support 460 000 people with an allocated budget of approximately $AUD 22 billion per annum (Bonyhady, 2014).

Increasing choice and control similarly features in the latest round of DES reform, whereby DES participants have been given more choice and control within a more contested market to determine which DES provider they use, and to change providers if they are not satisfied (DSS, 2016b). The most recent reforms implemented in July 2018 have been resourced with a significantly increased budget of approximately $AUD 900 million per annum. It is assumed that these reforms will incentivise DES providers to be more responsive to participants needs, ultimately leading to improved employment outcomes (DSS, 2017a). The political discourse aligns increased DES participant choice and control with the rights of people with disabilities. Yet some commentators argue that this seems somewhat inconsistent with the fact that the majority of participants engage with DES as part of tightening Welfare-to-Work policies that obligate welfare recipients to actively pursue employment (Nevile, 2012). Others remain critical not of mutual obligation per se, but the fact that insufficient efforts are made to address the underlying structural barriers to work for people with psychosocial disability (e.g. discrimination, social inequalities and the limited supply of jobs) (Nevile, 2012; Slade & Longden, 2015). People with psychosocial disability account for 38.9 per cent of the approx. 213 000 current DES participants (DSS, 2020).

Concern has been raised that people with psychosocial disability are finding it difficult to access and benefit from the NDIS, let alone exercise choice and control within it (Joint Standing Committee on the NDIS, 2017; Smith-Merry, Hancock, Gilroy, Llewellyn, & Yen, 2018). Approximately 8 per cent of

the approximated 277 000 current participants are reported to have a psychosocial disability. This is compared to the anticipated 13.9 per cent of the total NDIS cohort by 2019-2020. It also compares to the 230 000 Australians with significant mental illness estimated to require some form of community support, and, the 3.8 million Australians (of the estimated population of 25 million) that are reported to have some form of mental illness each year (AIHW, 2018; Joint Standing Committee on the NDIS, 2017; NDIA, 2018; NDIA, 2019b).

The lower than expected uptake of people with psychosocial disability within the NDIS has been associated with a variety of issues. This includes confusion about whether the definition of disability used by the NDIA means that people with mental illness with episodic conditions and fluctuating support needs meet the eligibility criteria of having a 'permanent' disability. Compounding this are the challenges experienced by people with mental illness in gathering the required evidence to determine eligibility and difficulty accessing adequate information and support to negotiate the application process. The higher than average rejection rates of people with psychosocial disability trying to access the NDIS has also been attributed to the limited mental health experience of NDIS staff (Joint Standing Committee on the NDIS, 2017; Smith-Merry et al., 2018). Indeed, the NDIS is reported to be significantly hindered in all aspects of its implementation by the federal Government policy introduced in 2014 capping staff numbers at less than a third of the 10 000 staff recommended by the Productivity Commission as required to effectively implemented the NDIS (Gringold, 2019; Productivity Commission, 2011, 2017).

At the same time Australia's mental health system which receives approximately $9 billion per annum is undergoing significant reform. This is alongside disruptions in mental health resource allocation as a number of Commonwealth and state and territory funded programs transition across to the NDIS (AIHW, 2018; Joint Standing Committee on the NDIS, 2017). These factors are contributing to significant uncertainty and mental health service gaps for people with psychosocial disability both within and external to the NDIA. Reduced access to mental health support greatly impacts on the employment outcomes of people with psychosocial disability, including those who are in receipt of the NDIS. Recent reporting indicates 23 per cent of NDIS participants aged 15 years and over are currently working, compared to the NDIA target of 32 per cent by 2022. For participants with psychosocial disability the current employment rate stands at 15 per cent (NDIA, 2018). This is of considerable concern not only for individuals but for the viability of the NDIS and has led the DSS and NDIA to develop a NDIS Participant Employment Taskforce (NDIA, 2019b; NDIA, 2019c).

Within its mandate, the Taskforce will try to clarify the roles and responsibilities of the NDIS and DES in relation to employment supports with the specific objective of developing a seamless interface between the two programs. The interaction of the NDIS and DES systems occurs when either existing DES participants gain access to the NDIS or when an NDIS participant requests employment support within their package. DES are recognised as the primary source of employment assistance for NDIS participants, responsible for assisting participants to build skills to participate in work and to assist them to gain and maintain employment, including providing on-going support where required (NDIA, 2014). A key issue with this interface is that NDIS participants are not able to access DES if they don't meet the DES program's eight hour per week with intervention work capacity benchmark criteria (Kane, 2019). If not eligible, NDIS participants may use their packages to access support to develop work-related skills (e.g. transport training, communication skills). However, the NDIS will not fund skills development that should be funded by employers or DES or other sectors. Covering the cost of undertaking further studies, for example, falls outside of the scope of the NDIS. Another issue that has been identified is that some Local Area Coordinators (LAC) responsible for supporting participants to develop NDIS plans are often not aware of DES, so even if participants are encouraged to include employment in their plans they are not always linked into available services (NDIA, 2019c). This paper will therefore assist policy actors to better understand issues at the interface of these programs, as well as examine broader factors which hinder the effectiveness of the NDIS and DES reforms to support people with psychosocial disability to attain the right to work.

7.2 Methods

This mixed-methodology study was embedded within a larger research project known as the Improving Disability Employment Study (IDES). IDES is implemented by the University of Melbourne in partnership with disability and employment services peak bodies, and, nine DES providers and one mainstream employment service provider. IDES aims to improve understanding of factors that promote sustainable employment outcomes for Australians with disabilities. IDES involves a prospective cohort quantitative survey of 369 people with disabilities currently accessing employment services. Alongside the IDES survey, qualitative data was collected through 56 in-depth interviews with 30 DES participants with psychosocial disability to more deeply explore their engagement with DES and work.

Recruitment and data collection

IDES survey respondents were recruited through partner employment services, either directly through frontline workers or via an email link sent to clients. A total of 369 people with disabilities

participated in the pilot (n=32) and Wave 1 (n=337) of the survey. Participants had the option of completing the survey on line or via Computer-assisted Telephone Interview (CATI). The survey took 30-45 minutes to complete and explored functioning, health and well-being, socio-economic conditions, and engagement with employment services and work. Survey participants will be asked to complete a follow-up survey approximately 12 months after they completed Wave 1.

Qualitative participants were divided across two cohorts, one recruited prior to and one after the implementation of the July 2018 reforms. Two methods of recruitment were utilized: 1) through the IDES pilot and Wave 1 survey, and 2) directly through DES providers. Potential participants included IDES survey respondents who: 1) had given prior consent to be contacted for follow-up interviews, and 2) had been identified through self-report within the survey as having a psychosocial disability. Eligible potential participants were contacted by the lead author and provided with information about the qualitative interviews. DES frontline staff working with people with psychosocial disability also provided potential participants with information about the qualitative study in the form of a flyer and Plain Language Statement. Participants were asked to complete two semi-structured interviews with an interval of six months in between. Interviews were completed between November 2017 and April 2019. Across the two interviews, participants were asked to reflect on their mental health, work and broader life circumstances and how this was influenced by DES. Interviews were audio-recorded and later transcribed. Participants of both the survey and qualitative interviews were all 18 years or over with informed consent collected prior to each survey and interview.

Data variables and analysis

The IDES survey demographic and socio-economic variables included age, gender, education, and ethnicity. Variables on employment, housing, transport and finances were adapted from the Australian Survey of Disability, Aging and Carers (SDAC), Life Opportunities Survey, and the Household, Income and Labour Dynamics in Australia (HILDA) Survey with some items also developed by the research team (ABS, 2015a; McManus & Lord, 2012; Wilkins & Wooden, 2013). IDES respondents were defined as having a psychosocial disability through self-report (i.e. reported their main disability was psychological) and the Washington Group (WG) Short Set and Extended Sets. The Washington Group on Disability Statistics designed these sets to identify people at risk of disability through nationally-based surveys. The Extended Set items used included pain, fatigue and affect items (anxiety and depression) with responses measuring frequency and severity of symptoms (Washington Group on Disability Statistics et al., 2010). If a person did not self-report a specific disability they were assigned to the psychosocial disability group if their main reported difficulties

(i.e. no other or less difficulties in other domains) across the Extended Set included daily or weekly anxiety or depression with the level reported as *'a lot'* or '*somewhere in between a little and a lot'.* IDES survey data was entered into Stata 15 for analysis (StataCorp, 2017). Descriptive analysis of the combined pilot and Wave 1 data was undertaken to determine demographic and socio-economic characteristics (e.g. age, gender, education, access to NDIS), and experiences in the labour market (e.g. access to paid work, factors impacting on access to work, discrimination) of participants.

Qualitative data analysis began with a deductive review of each transcript drawing on the research objectives and literature on DES, NDIS and work. An inductive process was then utilised to identify further codes emerging from the data such as examples of choice and control. A thematic coding framework was then developed based on this inductive analysis and the research objectives. Data were then re-analysed using a thematic approach to analysis as described by Braun and Clarke (2006).

Ethics and funding

Ethics approval for the IDES project and the nested qualitative study was obtained from the University of Melbourne Health Sciences Human Ethics Sub Committee (1545810.1 and 1750133.1). IDES is funded through an Australian Research Council Linkage Project Grant (LP150100077).

7.3 Findings

The findings provide a demographic overview of the IDES respondents and qualitative interview participants, before going onto to describe their engagement with DES and the labour market. This section then outlines findings relevant to the interaction between the NDIS and DES, including key factors undermining effectiveness across and at the intersection of these programs.

Demographics

Psychosocial disability was reported as the main disability experienced by 48 per cent of the IDES respondents, followed by physical disability (33.1%), cognitive (9.8%), other/multiple (5.7%) and sensory disability (3.5%). Half the cohort reported a secondary disability including 21.5 per cent of people with psychosocial disability reporting a co-occurring physical disability and 45.8 per cent of all other participants reporting a co-occurring psychosocial disability. Participants with psychosocial disability were the sub-group most likely to have attained post-secondary qualifications. The majority of respondents with psychosocial disability reported receiving the Newstart income support

payment. People with psychosocial disability were significantly less likely to receive the Disability Support Pension (DSP). (See Table 7.1).

Qualitative interview participants were between 21 and 57 years of age with an average age of 36.5 years. Half the cohort identified as male with just under half identifying as female and one person identifying as gender non-binary. The majority (80%) of participants reported depression and/or anxiety as the main condition contributing to their disability, followed by Schizophrenia/Psychosis (13.3%) and Post-Traumatic Stress Disorder (6.6%). Two-thirds of participants were living in an urban or semi-urban area with the remainder living in regional or rural areas. Many participants reported disrupted education, with nearly a third not completing secondary school often due to their own mental health or that of family members, and, lack of support within the education system or a combination of all these factors.

Table 7.1 IDES survey respondent demographics

Variable		Psychosocial n(%)	Combined other n(%)	Total n(%)
Age	18-24	21 (11.9)	24 (12.5)	45 (12.2)
	25-34	52 (29.4)	35 (18.2)	87 (23.6)
	35-49	60 (33.9)	46 (23.9)	106 (28.7)
	50-64	42 (23.7)	84 (43.7)	126 (34.2)
	65 and over	2 (1.1)	2 (1.0)	4 (1.1)
Gender	Female	118 (66.7)	94 (49.0)	212 (57.5)
	Male	58 (32.8)	96 (50.0)	154 (41.7)
	Gender non-binary	1 (0.6)	2 (1.0)	3 (0.8)
Reporting other disabilities	Physical	38 (21.5)	15 (7.8)	53 (14.4)
	Sensory	11 (6.2)	29 (15.1)	40 (10.8)
	Psychosocial	5 (2.8)	88 (45.8)	94 (25.5)
Schooling	Mainstream	163 (92.1)	167 (87)	330 (89.4)
	Special/integrated	4 (2.2)	14 (7.3)	20 (5.4)
Highest level of schooling	Year 12	96 (54.2)	86(44.8)	182 (49.3)
	Year 11	27 (15.3)	37(19.3)	64 (17.3)
	Year 10	33 (18.6)	46(24.0)	79 (21.4)
	Some high school <Y10	18 (10.2)	21 (11.0)	39 (10.6)
	< Primary school	2 (1.1)	1 (0.5)	3 (0.8)
Post-school qualifications	None	32 (18.1)	48(25.0)	80 (21.7)
	Apprenticeship/trade certificate	27 (15.3)	35(18.2)	62 (16.8)
	Other certificate (I-IV)	55 (31.1)	62(32.3)	117 (31.7)
	Associate degree/diploma	27 (15.3)	24(12.5)	51 (13.8)
	University degree	35 (19.8)	21(11.0)	56 (15.2)
Type of income support/welfare benefit	Newstart	131 (74.4)	142 (74.7)	273 (75.6)
	DSP	27 (15.34)	51 (26.6)	78 (21.2)
NDIS recipient	Yes	7 (3.9)	15 (7.8)	22 (6.0)
Compulsory engagement in DES	Yes	135 (76.3)	145 (76.7)	280 (76.5)
Choice in provider	Yes	64 (48.9)	74 (51.7)	138 (50.4)

Engaged with current DES provider for 12 months of more	Yes	86 (53.4)	74 (43.5)	160 (48.8)
Volunteered in the last 6 months	Yes	46 (26.1)	52 (27.6)	99 (26.9)
Ever been in paid employment	Yes	160 (90.4)	173 (90.1)	333 (90.3)
Currently in paid employment if ever worked	Yes	54 (33.7)	43 (24.9)	97 (29.1)
	Total	**177 (48.0)**	**192 (52.0)**	**369 (100)**

Engagement with DES

Respondents with psychosocial disability were more likely to have been engaged with their current provider DES for 12 months or longer, indicative of longer periods of unemployment. Approximately 76 per cent of IDES survey respondents with psychosocial disability were engaged with DES as part of mutual obligations attached to their income support. Of these, less than half (48.9%) reported they exercised choice in which provider they were referred to. (See Table 7.1). When choice was afforded, DES related factors most commonly reported as important in influencing respondents' choice in providers included providers 'making me feel welcome' and 'easy to get to' (76.5% of respondents), and 'experience with my disability' (75%).

Just over half of all qualitative interview participants engaged with DES as part of their mutual obligation requirements, with the remaining participants reporting they were voluntarily seeking support through DES. A small number of qualitative participants reported actively choosing to stay with their current DES provider as they were happy with the support they had received. Many participants expressed dissatisfaction with their current provider yet only one participant (recruited post-reform) reported changing providers. This was reportedly enabled through the support of the NDIS support worker.

> *I left* [previous provider] *because I found I kept going to the appointments all the time and they never really found me anything. When I was talking to my support worker about it, she said just across from their office there was another disability employment agency … So she said 'I will talk to her and see if I can get you in there', so she did. And then they helped me to go to Centrelink* [agency responsible for overseeing welfare payments] *and then I transferred across. Because I just found I kept going to* [previous provider] *but the girl was suggesting*

> *things that* [meant] *I understood she didn't understand me and my illness.* (P17b: Participant #17, follow-up interview)

For most, exercising control to change providers if they were not happy was undermined by program-related and external factors. Program-related factors included limited knowledge about their right to change, limited availability of information to differentiate between DES providers, or not wanting to have to re-tell their story to a new provider. External factors described by participants included needing to prioritise broader life circumstances over both engagement with DES and the labour market. Finding suitable housing for example or trying to address complex mental health concerns made changing DES providers somewhat irrelevant. Some participants also stayed with their current provider to avoid upsetting their employment consultant, or, they felt they would need more external support than was currently available to activate change.

Experiences in the labour market

In terms of engagement with the labour market, 29 per cent of all IDES respondents reported they were currently in paid work with 90 per cent reporting they had been in paid work at some point. (See Table 7.1). Of those who did report previous paid employment, 33.4 per cent of people with psychosocial disability were currently working, the majority of whom began their most recent job in the last 12 months (59.6%). When asked how they got their most recent job the majority of people with psychosocial disability (n=25, 46.3%) reported 'applying after seeing an advertisement', followed by 'assisted by employment provider' (n=15, 27.8%).

In terms of participants working arrangements, 40.7 per cent reported they were on a permanent/ongoing contract, with 42.5 per cent reporting they were casually or temporarily employed. Of those currently working, 48.2 per cent reported they would like to work more hours than they currently do. Similarly, 51 per cent of respondents with psychosocial disability responded to an open-ended item asking 'why are you looking for another job', with the most commonly reported reason stated as 'wanting to find a different job' (33.3%), followed by 'seeking more hours' (23.5%).

At the time of first interview, five of the qualitative interview participants were currently working part-time but were required or aspired to gain more hours; 22 were unemployed; and three were volunteering but hoping to gain paid employment. Of the 26 participants that completed the qualitative follow-up interview, four were in full-time paid employment, with two people working part time whilst studying. Twenty reported they were not currently working, with four studying

whilst looking for work; three volunteering and looking for work; two volunteering and studying; and, eight unemployed and not studying or volunteering. One participant had recently had a baby and had moved onto a parenting payment and was no longer engaged with DES or the labour market. Four participants did not participate in the follow-up interview due to mental health and/or loss of contact with DES.

Employment related difficulties and barriers to employment

When asked about employment related difficulties, IDES respondents with psychosocial disability most commonly reported 'finding suitable work' as creating a lot of difficulty when trying to find work (52.0%). Similarly, the most commonly reported factor to greatly affect access to work was the 'lack of jobs close to where I live' (39.6%). This was followed by 'lack of skills and qualifications' (37.9%) and 'lack of confidence' (36.9%). (See Table 7.2). Just under half (48.0%) of respondents with psychosocial disability reported experiencing discrimination in their lives because of their disability or health condition. In relation to the labour market, 18.3 per cent reported experiencing discrimination 'when looking for work'; 28.6 per cent 'when applying for jobs'; and, 20.2 per cent 'during the interview process.'

Table 7.2 Employment related difficulties and factors impacting on gaining and maintaining work for IDES respondents with psychosocial disability

	No Difficulty n(%)	**Some difficulty n(%)**	**A lot of difficulty n(%)**
Type of job you can do	37 (21.4)	88 (50.9)	48 (27.7)
Number of hours	51 (29.5)	79 (45.7)	43 (24.9)
Finding suitable work	12 (6.9)	71 (41.0)	90 (52.0)
Needing time off work	71 (42.0)	65 (28.5)	33 (19.5)
Factors impacting on access to work	**Does not affect n(%)**	**Somewhat affects n(%)**	**Greatly affects n(%)**
Lack of access to transport	97 (55.1)	38 (21.6)	41 (23.3)
Lack of jobs close to where I live	34 (19.5)	71 (40.8)	69 (39.6)
Family responsibilities	118 (67.1)	33 (18.8)	25 (14.2)
Caring for others	133 (75.1)	37 (20.9)	7 (3.9)
Lack of family assistance	104 (59.8)	45 (25.9)	25 (14.4)
Lack of confidence	33 (18.8)	78 (44.3)	65 (36.9)
Lack of skills/qualifications	44 (24.9)	66 (37.3)	67 (37.9)
Financial/Centrelink benefits I receive*	69 (40.1)	57 (33.1)	46 (26.7)

Numerous barriers to employment were described by qualitative participants including family breakdown, disrupted education, unemployment, traumatic life events, poor physical health, homelessness, discrimination, and, significant financial hardship. These factors often intertwined to

influence mental health, engagement with DES, and the ability to find and keep work, particularly in areas where there seemed to be limited jobs that met the self-beliefs, aspirations and skills of participants. These findings are discussed in more detail in the following sections.

> *I started about a year ago. I asked a lot of cafes on* [name of local shopping street] *you know my friends. I asked them if they could give me a job and they tell me 'You can't do it', 'No you're on the disability pension', 'You need to have a disability agency'. I even went to* [local employers] *and asked them if they had any work as a cleaner and they said 'No you need disability work'* [i.e. employment setting specifically for people with disabilities and not open employment]*. They are right because I have to admit I can't do normal jobs like a normal worker, I have to look for disability work.* (P2a: Participant #2, baseline)

Interaction between DES and the NDIS

Twenty-two IDES respondents (approximately 6%) were receiving support through the NDIS of which seven were people with psychosocial disability. More than two-thirds of these NDIS participants had employment included as a goal in their current NDIS plan, including five of the recipients with psychosocial disability. A further five respondents with psychosocial disability were unsure if they were currently receiving NDIS support. Two qualitative participants were currently receiving NDIS support, whilst a number of others described factors they felt were impacting on their access to the NDIS. This included confusion regarding eligibility and the role of mental health providers in supporting access: 'From what I'm hearing in the community, people are just so overwhelmed and confused and they don't think their case managers know what they are doing and they don't know what they are eligible for.' (P1a).

> *Well I don't know anything about it. No one has told me anything about it. Other than the mental health service provider, the guy that comes around and visits, that will discontinue …* [I]: That will discontinue? [P]: *Yeah and then NDIS will kick in. But there is no information being given from the government, except what I have been told through him.* [I]: And he says you will be eligible? [P]: *Yeah* [I]: But they haven't started making a plan? [P]: *No … I have no idea how it works … But if this mental health service provider, he has been really useful, and if that is not continued that will create more problems.* (P9a)

> *They rang me up like a year ago and stupid me, they said you know blah blah and that could have started our way on the NDIS program. But I thought it was going to interfere with my*

> [income support] *payments from Centrelink, and I wasn't ready to go on the NDIS program you know. So now I am not on. So now I have to try and get on.* (P18a)

For those that were currently accessing NDIS support, there was little discussion regarding how NDIS and DES may work together to support people to gain and maintain employment. There was however some reference to support workers attending DES appointments. These interactions often highlighted issues of trust which may undermine collaboration.

> [I]: What about through your NDIS package? Have you put employment in there as a goal?
> [P]: *It's down there, but I don't figure for support, just as a goal … I spoke to my counsellor and she told me to leave here* [current DES provider] *because she thought it was being detrimental to my mental health, because coming into* [current DES provider] *and not getting the help I required was getting me down … According to her employment services are not particularly supportive and don't meet the expectations of people that go there … I have heard that too… I ended up having to take my support worker in with me for the last two interviews* [with DES worker] *because she felt like I wasn't getting listened to.* (P3b)

Some respondents reported DES staff were unsure about how they could support NDIS participants who were accessing DES, particularly if people required more support than is often made available through the DES provider: 'I have heard a few people say 'This is ridiculous', or 'I don't know how they can work with that little amount of money' or 'what do they can expect me to be able to do for them' … I think the NDIS was just rushed out too quickly.' (P24b). This was specifically seen as an issue for people with psychosocial disability that may require more ongoing support than both NDIS and DES seem able to accommodate: 'I just sort of think that maybe not enough attention is paid once you have got a job … I can see the staff here have enough to do without post-placement support on top of them.' (P24b). Likewise, nearly 60 per cent of IDES respondents with psychosocial disability reported wanting DES to provide them with 'support once I have a job'. Second only to 64 per cent of these respondents wanting DES to provide them with support *'to feel confident in my abilities'.*

Key factors undermining the effectiveness of DES and the NDIS in supporting people into work

Alongside limited availability of jobs, the most common issues undermining the effectiveness of DES and the NDIS to support people into work were housing and access to mental health support. In relation to housing, 71.5 per cent of IDES respondents with psychosocial disability reported they were currently living in a private residence, yet 4.5 per cent were currently sleeping rough or in

temporary accommodation, and, 14.2 per cent had experiencing homelessness in the last 6 months. More than 35 per cent also reported they had moved house in the last 5 years on account of their disability with people moving on average 2.3 times (range 0-13) in this period. The qualitative findings demonstrate more deeply the relationship between housing, disability and employment. The lack of accessible, affordable and secure housing was consistently reported as a significant barrier to engaging with DES and the labour market, with some optimism that the NDIS could play a role in addressing these compounding issues.

> *The last formal application to Housing was with my daughter but now it's just an application for myself. I pretty much lost my parenting rights by not having housing for those years … I am on the highest priority which is homelessness … It is a matter of somebody dying at this point in public housing to get into something. So it feels a pretty long way away. But I have worked out a way around it … Under the NDIS they are promoting housing as well as their abilities to help. Although I know they won't have any more access to housing than public housing … I was going for jobs with the NDIS, to work in the NDIS. Probably just over a month ago I just gave up looking for work, because I don't have anywhere to live … So I thought I am going to apply* [NDIS] *because I saw housing is something that they can help you with.* (P1b)

Despite this optimism the experience of other participants highlights concerns regarding the ability of the NDIS to address the unmet need for housing for people with psychosocial disability. For example, participants were not always afforded choice and control within the NDIS to access the housing support they felt they most required. This in turn made it difficult to engage with DES and work.

> *I was a bit disappointed in that the things that I asked for* [in NDIS planning] *and I think are really important to me and I really needed. I was asking if I could get a housing support worker… They just sort of brushed it off … I went to them for a little while* [new DES provider]. *I went with my support worker because I went a little bit downhill. And I asked if I could have a month or two break* [from engaging with DES] *…. I would love to have a part-time job …When you live somewhere and you know that you can be there for the foreseeable future … you are more grounded to be able to make better choices, to actually want to go and find a job.*

Even when participants did manage to get housing support in their NDIS plan, the lack of housing and support services meant the unmet need for housing remained a persistent barrier to finding work.

I didn't do the plan alone. I did it with one of my support team from [mental health provider]. *So she helped me and she said that she doesn't know where it's coming from or how to work it out. So I haven't got anyone working towards housing, but it's part of the* [NDIS] *plan so hopefully I get more assistance with getting my own place because then I can see my daughter more often.* (P3a)

I got hooked in with one housing support coordinator and he did one session and then he said he was moving location so he couldn't take me on … And then I got a second housing coordinator after waiting for about three months, and then she was wanting to make appointments on the weekend, which is getting the highest amount from the list item. So my support worker got angry with her. So now I don't have another housing support worker yet … I am just looking for housing, which is not really going anywhere, which is taking up a lot of time as well as looking for jobs. (P3b)

Alongside housing difficulties, interview participants described changing access to mental health services that were negatively impacting on their mental health: 'I have a mental health nurse practitioner. That's changed a bit. I don't see him as much as I used to. He used to be like a bit of a mentor as well and now I feel like he is stepping back a bit and doesn't come over for home visits.' (P8b). For some participants this was specifically related to the introduction of the NDIS. This impacted on people both engaged with and not yet engaged with the NDIS: 'They [mental health service provider] sent him a letter saying 'you failed to provide us with a care-plan. We are not going to look after you as a client'. But as far as I'm concerned it's their job to do a care-plan'. (P1b)

The mental health support worker at [mental health provider] *is basically having to close the door soon, which is a little bit of a concern, as things are rolled over into the NDIS … This guy that currently provides me with a service, he is going to move on, because he is not willing to accept the hourly rate that is offered under the NDIS. What you are going to be having, is having people without the same level of experience …* [I]: So do you have an NDIS package now? [P]: *No I haven't been offered anything. There has been no communication whatsoever, or there might have been something one letter, but I really don't know.* [I]: So then you are not sure what will happen to your [mental health provider] services? Or they will continue for a little bit longer? [P]: *Yes that's right but they have already been scaled back in terms of what they can offer, but what they can offer is pretty extraordinary at the moment I must say.* (P9b)

7.4 Discussion

Inline with our ratification of the UNCRPD, the Australian policy context increasingly emphasises the goal of supporting people with disabilities to attain their human rights on an equal basis with Australians without disability. Key policies promoted as critical to achieving this goal include the NDIS and DES. Both programs however have been criticiqued as not yet effectively addressing the barriers experiened by people with psychosocial disability that undermine attainment of their rights (Joint Standing Committee on the NDIS, 2017; Waghorn et al., 2007). With a focus on the right to work, our findings highlight that the effectiveness of these programs are hindered by persistent barriers to employment encountered by people with psychosocial disability within these programs, as well as in the wider social and policy contexts in which they live. The key issues identified by participants include underemployment, unmet housing needs, disruption to mental health supports, limited supply of jobs, lack of skills and qualifications, and diminished self-confidence in relation to finding and maintaining work.

The NDIS and DES both intergrate elements of NPM with a discourse on the rights of people with disabilities to exercise choice and control in their engagement within the confines of each program. Comparable with other research, this study demonstrates that the same socio-economic barriers which undermine the right to work similarly influence individual capability to exercise choice and control within disability and welfare policies such as the NDIS and DES (Arstein-Kerslake, 2017; Collyer et al., 2015; J. Jenkinson, 1993). However the findings also highlight that participant capability for exercising choice and control within these programs is not only constrained by broader socio-economic conditions, but by challenges within how the programs themselves are implemented. This was clearly illustrated within examples where participants described their confusion regarding their access to the NDIS. For NDIS recipients, it was evidenced by their distress that their self-identified need for support to access housing was disregarded by NDIS planners or remained unmet due to limited housing support and housing availability. In turn, when participants were not able to exercise choice and control in utilising their NDIS package to address what they identified as their most significant barriers to employment, their capability to engage with DES and the program's effectiveness in supporting their right to work is hindered.

So what can be done to address the constraints within and across the implementation of the NDIS and DES to ensure more people with psychosocial disability are better supported to enhance their autonomy and realise the right to work? Internal monitoring within the NDIS highlights participants are more likely to be working if they have a work goal and employment support clearly articulated

and resourced in their plan; higher level of independence with daily living activities; positive levels of social and community inclusion; and previous work or volunteer experience; and, university qualifications. Participants were less likely to be working if they had higher support needs and reduced independence; living in a local government area where there is high unemployment rates of 8 per cent of more; higher age at entry into the NDIS; and, lower interaction with the community (NDIA, 2018). Whilst these findings clearly reiterate the broader structural barriers to work experienced by NDIS participants, they also highlight potential areas amenable to intervention within the implementation of the NDIS that may in turn support engagement with DES and work.

Enhancing the capacity of NDIS planners to better understand the work capabilities of people with disabilities and then encouraging participants to include work as a specific goal is something that can be readily addressed by the NDIA/DSS Participant Employment Taskforce that is due to release its first report at the end of June 2019 (DSS, 2019e). However it also requires the NDIA to match employment goals with appropriate resourcing and supports identified by people with disabilities as hindering their access to work. This comes back to improving policy understanding of the interaction of barriers which undermine access to work, as well as ensuring much greater recognition is given to the expertise of people with disabilities in identifying what is required to address these barriers and their capability to exercise choice and control to utilise their NDIS packages to most appropriately address these barriers (Souza, 2019).

As noted above, previous work and volunteering experience promotes access to work for NDIS participants. The NDIA was also seen by our study participants as a potential employment opportunity. Indeed, DSS has previously promoted the NDIS as a major employment opportunity for the increasing numbers of people with disabilities engaged in DES (DSS, 2018c). Improving employment rates of people with disabilities within the NDIA also aligns with the newly re-elected Federal government's recent announcement that it would 'fix problems within the NDIS' and try to further address unemployment of Australians with disabilities, including through a recent pledge to implement a 7 per cent disability employment target in the Australian Public Service. The current rate is 3.7 per cent, having continuously fallen from a high of 6.6 per cent in 1986 (Michael, 2019a, 2019c). A more recent announcement has seen the government create a NDIS Ministerial position within cabinet, taking overarching governance responsibility for the NDIS out of the DSS (Michael, 2019b). There is yet no indication what measures will be taken by the new Minister to address the issues identified with its implementation.

It is clear however that collaboration between the NDIS and DES is required to improve trust and knowledge between the programs and address current implementation challenges occurring at their

intersection. Specifically, more clarity is required on the role of DES providers in supporting NDIS participants to access work as well as how DES can better support its participants to access the NDIS if required, through enhance NDIS knowledge and referral pathways. Strategies to address the 8 hour benchmark requirement that is hindering access to DES for some NDIS participants that currently don't meet this requirement are also required (DSS, 2019e; Kane, 2019; NDIA, 2019c). Strategies could include resourcing a specific stream within DES to support NDIS participants that require a higher level of support to address vocational barriers to employment and support to remain in work than is currently available through DES. Similarly, DES expertise in employment could support the NDIA to develop employment pathways for people with disabilities within the NDIA, as well as working with NDIS participants through DES to develop their skills and qualifications to engage with such pathways. Others have also called for more lived experience of disability within all levels and roles of the NDIA (Hayes-Brown, 2019).

In relation to people with psychosocial disability more specifically, the NDIS presents a new opportunity to re-examine how DES could be more adequately resourced to enable the implementation of evidenced-based practices that have been difficult to operationalise within the Australian DES context. Individual Placement and Support (IPS) for example are widely recognised as the most effective employment intervention for people with psychosocial disability (Parletta, 2015; Sherring et al., 2010; Suijkerbuijk et al., 2017; Waghorn et al., 2007; Waghorn et al., 2014; Waghorn & Hielscher, 2015). Among the eight key principles of IPS is the co-location of mental health and employment services, and, the rapid placement of job seekers into employment. Integration of mental health and employment services within Australia is currently problematic given these programs function under separate funding and contractual arrangements (R. King et al., 2006; Morris et al., 2014; Parletta, 2015; Waghorn et al., 2007; Waghorn & Hielscher, 2015). Exploring how the NDIS could be utilised as a platform to better enable integration of mental health and DES not only opens up potential to implement evidence-based employment support, but also presents an opportunity to improve the collaboration between the NDIA and these two sectors. Collaboration across these sectors may then enable policy makers to better understand and address broader structural inequalities hindering the effectiveness of these sectors to improve the mental health and employment outcomes of people with psychosocial disability.

The government has responded to calls to improve the capability of the NDIS to engage with people with psychosocial disability by introducing a specific psychosocial disability stream and an NDIA Mental Health Sector Reference Group (DSS, 2018b). This has led to the recruitment of specialised

planners and LACs to support people with psychosocial disability to access and more appropriately benefit from the NDIS, including people with episodic support needs (NDIA, 2018). It is not yet clear however if strategies to improve employment outcomes or capabilities for choice and control for people with psychosocial disability are being proactively encouraged through this stream. Key factors that have been found to promote choice and control within social policies such as the NDIS and DES include recognition of the capacity of people with psychosocial disability to make decisions about their own lives, (albeit recognising some people desire and require support to make these decisions); opportunities for peer support and advocacy; adequate information and education on what services are available and how to access these services; and increasing opportunities for the voice of people with psychosocial disability to inform the development, implementation and evaluation of services (Brophy, Bruxner, Wilson, et al., 2014; Carroll et al., 2016; Warr et al., 2017). These are all areas that require ongoing resourcing across all relevant policies including the NDIS and DES to more effectively support independence for decision-making and better meet the needs of people with psychosocial disability across their lifetimes.

Yet even if the NDIS and DES effectively address current implementation issues within each program and the interface between the two that hinder their efforts to support people with psychosocial disability to gain the right to work, improving employment outcomes requires persistent structural barriers and inequities within the broader social and policy context to be addressed (Slade & Longden, 2015). Key policy areas critical to this include housing and the urgent need to increase the availability of accessible, affordable and sustainable housing solutions for people with disabilities across Australia (Aitken et al., 2019). Enhanced resourcing of all levels of the mental health system is also required to better support the 3.8 million Australians reported to experience some form of mental illness each year, both those within and those excluded from the NDIS. This includes giving greater attention to the social determinants of mental health and addressing the social inequalities experienced by people with psychosocial disability that contribute to the disabling environments in which they live (Kavanagh et al., 2016; Lund et al., 2018; Mithen et al., 2015). Finally, governments and communities, together with the NDIS and DES, need to work together to ensure we are creating sufficient, sustainable and meaningful employment opportunities for all people with disabilities that want to work (O'Brien & Dempsey, 2004; Slade & Longden, 2015).

7.5 Conclusion

People with disabilities have fought hard to gain recognition for their rights as articulated in the UNCRPD, yet people with psychosocial disability in particular continue to experience significant barriers in the attainment of these rights (Drew et al., 2011; Glendinning, 2008; Kayess & French, 2008). This paper examined this issue by focusing on the right to work of Australians with psychosocial disability in the context of NPM-inspired marketization of disability and welfare policies. Despite the limitations of this study in terms of the limited number of study participants currently engaged with both DES and the NDIS and the small number of partner organisations these participants were recruited from, our findings highlight the challenges people psychosocial disability are experiencing within two key examples of disability and welfare policies that have been influenced by NPM. Factors that undermine choice and control within the NDIS had the flow-on effect of undermining engagement in DES and compounding barriers to the right to work. Improving program effectiveness however not only requires challenges within and across the implementation of these two programs to be addressed, but requires Australian Governments and communities to address the socio-economic inequalities and structural barriers that continue to prevent people with psychosocial people attaining the right to work. Perhaps the most important places to start are to improve community understanding of psychosocial disability and the need to better support people with psychosocial disability to access all available services, including through the NDIS to help them realise their rights. However, the limitations of NPM inspired marketization of disability and welfare policies in truly supporting all people with disabilities to attain their rights on an equal basis with others, must also be recognised.

Chapter summary

Subsequent to the submission of this paper, the NDIS Participant Employment Taskforce released their Employment Strategy in November 2019 (NDIA, 2019a, p. 28). Despite the Taskforce's mandate to clarify the roles and responsibilities at the NDIS and DES interface, there is scant reference to - let alone clarification of - this issue within the new strategy. The strategy states that the NDIS works closely with DES and other service systems, by complementing and not duplicating existing systems, with year one of the strategy actioning the publication of clear information about how the NDIS and DES will work better together. Yet the detail of how this will be achieved is absent. Somewhat confusingly, the strategy also states a need for NDIS participants to experience less complexity within employment programs, by reducing the gaps between the NDIS and 'mainstream' employment services (NDIA, 2019d).

Greater clarity seems to be achieved in the NDIA Price Guide which outlines which services and supports can be funded under the Capacity Building category of finding and keeping a job. The Price Guide indicates that services and supports can be funded if they are *'likely to lead to successful engagement in a Disability Employment Service.'* (NDIA, 2019e, p. 40). Similarly, the NDIA expects that appropriate supports provided within the School Leaver Employment Supports (SLES) stream, will lead to the majority of SLES participants transitioning to DES to *'undertake the job seeking, placement and post placement support phases of their pathway.'* (NDIA, 2019e, p. 40). As observed by other authors, this indicates that the NDIA is now positioning itself as providing capacity building supports to NDIS participants prior to their engagement with DES (Cotton, 2019). This seems to be occurring at the expense of clarifying how the NDIS and DES interface may more effectively function to simultaneously complement support received within each program to support participants to find and maintain employment

As highlighted in this chapter, despite the visionary objective of the NDIS, people with psychosocial disability continue to experience challenges in exercising choice and control to address self-recognised barriers to employment. Factors such as insufficient access to mental health supports, housing insecurity, and, limited availability of jobs, remain difficult to address in the context of the NDIS. In turn, this can undermine engagement with DES and the labour market. These factors also influence how people exercise choice and control within welfare systems, as further explored in the following chapter.

Chapter Eight: 'I don't think they trust the choices I will make.'

Chapter Eight responds to RQ4, by documenting four unique narratives illustrative of DES participants' perspectives on choice and control within the context of DES. The paper presented was published in the journal *Public Management Review* (DOI: 10.1080/14719037.2019.1648700, August 2019). The paper draws on narrative analysis of the 14 baseline and 13 follow-up qualitative interviews with cohort one participants.

'*I don't think they trust the choices I will make.*' – Narrative analysis of choice and control for people with psychosocial disability within reform of the Australian Disability Employment Services program.

Authors: Alexandra Devine [a], Helen Dickinson[b], Lisa Brophy[c], Anne Kavanagh[a], and Cathy Vaughan[a]

[a] *Centre for Health Equity, Melbourne School of Population and Global Health, University of Melbourne*

[b] *Public Service Research Group, School of Business, University of New South Wales*

[c] *Centre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne, and, Social Work and Social Policy, La Trobe University*

ABSTRACT

This paper explores New Public Management-inspired reforms to Australia's Disability Employment Services (DES), which assume increasing participant choice and control within DES will enhance provider competition and effectiveness. However, capability for choice and control within this context is multifaceted. This is particularly so for participants who experience significant barriers to employment, as highlighted in our narrative analysis of the perspectives of DES participants with psychosocial disability and their resistance to exercising control to change providers despite dissatisfaction with outcomes. This brings into question whether increased marketization of DES will indeed support its objective of improving employment outcomes for people with disability.

Key words: New Public Management, employment services, psychosocial disability, choice and control

8.1 Introduction

The Australian Disability Employment Services (DES) program is the federal Government's specialised welfare program for people whose disability is assessed as their main barrier to gaining and maintaining employment (DSS, 2015b). As in other countries, Australian public services including employment services, have in recent years undergone somewhat of a transformation, inspired by ideas associated with a New Public Management (NPM) philosophy (Carey, Dickinson, Malbon, & Reeders, 2018; Considine et al., 2018; Hood, 1995; Osborne, 2006). DES services specifically have transitioned from being publically-funded and delivered to a quasi-market of government contracted for-profit and non-profit businesses who support and monitor the efforts of people with disabilities in receipt of income support (and a small number of voluntary participants) to actively promote their employability and participation in work (DSS 2016b; McDonald & Marston, 2008; Nevile & Lohmann, 2011; Olney, 2016). Under current reforms, there is emphasis on the need for consumer choice to further stimulate the effectiveness and efficiency of the market, with DES participants now given more choice and control within a contestable market to determine the provider they use and to change if not satisfied (DSS 2017a). At the same time, participants are subject to increasing compliance mechanisms including the threat of financial sanctions under ongoing Welfare-to-work reforms (Australian Government, 2018).

Within the context of newly reformed DES it is assumed that: a) participants will exercise choice and control; b) this will incentivise providers to be more efficient and responsive to participants needs as providers aim to improve services to retain existing customers and compete for new customers; ultimately leading to c) improved employment outcomes (DSS 2017a). These are untested assumptions within DES policy reform and research that require scrutiny. Understanding the perspectives of DES participants is critical in exploring these assumptions, particularly of those most likely to be excluded from work, such as people with psychosocial disability. Psychosocial disability can be conceptualised as disability associated with the lived experience of mental illness. It is influenced by the interaction of a person's psychological and cognitive condition, and, the socio-cultural context in which they live (NMHCCF, Drew et al.; Hayes et al., 2018). Not all people who experience mental illness will experience psychosocial disability. However, people with mental illness all too often experience disabling discrimination and exclusion across several life domains, frequently falling through the gaps of the plethora of siloed policies and outsourced services, diversely funded and managed across Australian federal, state and territory jurisdictions (Carroll et al., 2016; Olney, 2016; Productivity Commission, 2019b).

People with psychosocial disability experience socio-economic inequalities and poor health outcomes - both factors that influence capability for choice and control. These factors are also both causes and consequences of poorer employment outcomes, with this group experiencing some of the lowest labour force participation rates (29%) and highest unemployment rates (19%), compared to other people with disabilities (53.4% and 10% respectively), and, the general population (83.2% and 5%) (ABS, 2016; DSS 2016b; Harvey et al., 2016). These rates remain stagnant despite service reforms and the investment of close to $AUD 1 billion per year in DES (DSS 2017b).

The aim of this paper is to explore whether and how DES participants with psychosocial disability exercise choice and control to stay with or change providers. The first part of this paper discusses differing capabilities for choice and control within NPM-inspired social policies. Following a discussion of the research methods, the paper then goes on to present findings from 27 qualitative interviews with 14 DES participants with psychosocial disability. Drawing on narrative analysis of the data, four narrative positions were identified: 1) Actively choosing to stay with their current provider; 2) Passively staying; 3) Reluctantly staying; and, 4) Tinkering on the edge of change. Positions were influenced by current and previous service experiences and level of satisfaction with their current provider, mental health and employment outcomes, as well as the extent to which socio-economic factors constrain participants' capabilities for exercising choice and control. While a small number of participants actively chose to stay with their provider, no participants in our sample exercised control to change despite growing dissatisfaction. These findings contribute to better understanding of factors that hinder participant choice and control within quasi-markets, and lead us to question whether welfare reforms based on consumer choice will have the desired effect of stimulating the effectiveness of employment services in supporting people with disabilities to access work.

Differing capabilities for choice and control within NPM-inspired welfare quasi-markets

Much of the inspiration for the NPM philosophy was derived from private consumer market theories and a belief that introducing market strategies within public services would prompt providers of services to be more responsive to consumers, to both retain existing customers and attract new ones, thus improving organisational efficiency (Aberbach & Christensen, 2005; Dan & Andrews, 2016; Van de Walle & Marien, 2017). These theories also assume choices are made in isolation by well-informed, rational, voluntary and self-interested individuals with equal capabilities for decision-making (Clarke, Smith, & Vidler, 2006; Jilke, 2015). There is limited consideration within these theories of the complex circumstances that often influence the decision-making capabilities of individuals in need of or those compulsorily engaged with welfare services, arguably making such

theories less applicable to publically-funded welfare programs (Clarke et al., 2005; Glendinning, 2008). Decision-making processes and capability for choice and control are influenced by factors such as age, level of education, and cognitive capacity to gather and assess information to make, articulate and implement choices (Clarke et al., 2005; Jilke, 2015). These factors interact with broader issues, such as socio-economic inequalities, unemployment and discrimination, to further influence whether and how people make decisions, and their motivation, willingness and support to exercise choice and control within quasi-markets such as those created by policy reforms of programs such as DES (Burchardt et al., 2015; Carey et al., 2018; Crozier & Muenchberger, 2013; Glendinning, 2008; Purcal et al., 2014).

Consumer choice theories also presume that ideal consumers will engage with responsive markets that equally value the rights of consumers to choose which services they engage with and to exit if dissatisfied. This ignores the complexities of markets stemming from traditionally delivered public services such as health, welfare and disability (Clarke et al., 2005). In their research on the introduction of choice in public health services across Europe for example, Van de Wallen and Marien (2017) found that perceptions of choice and control are more reliant on individual attributes, personal health circumstances, location and level of satisfaction with the health system as opposed to the opportunity to freely choose which healthcare provider to go to. A similar confluence of systems-level factors (e.g. inaccessible information), service-level factors (power imbalances between providers and consumers), and individual level factors (e.g. family support, self-confidence, disability) have been shown to influence decision-making of people with disabilities in their engagement with vocational rehabilitation services (Shaw, MacKinnon, McWilliam, & Sumsion, 2004).

In other research, the opinion and choice of professionals and market-steward decision-makers has been shown to often prevail over that of consumers when determining what services should be purchased using personalised budgets within the marketization of disability services in Australia (Warr et al., 2017). Furthermore, for people with psychosocial disability, availability of support and resources to nurture independence in decision-making has often being restricted through legislation denying legal capacity, alongside institutionalisation and other forms of segregation. This impacts how these individuals exercise choice and control within their engagement with services (Arstein-Kerslake, 2017; Collyer et al., 2015; J. Jenkinson, 1993). Research therefore highlights the importance of nurturing agency, building trusting relationships with services, and facilitating skills for decision-making processes through-out service engagement (Knight et al., 2018; Parent, 1996).

Participant choice within quasi-markets is similarly undermined by a lack of accurate and accessible information to help consumers differentiate between providers, as well as limited mechanisms to support people to make informed choice about which provider may best suit their needs (Dan & Andrews, 2016). This contributes to information asymmetries and power imbalances within service decision-making, often favouring provider authority over consumer needs (AFDO, 2014; Glendinning, 2008; McDonald & Marston, 2008; Shaw et al., 2004). This risk could be exacerbated under the reforms as information on provider effectiveness provided by DSS will be limited for at least the first 12 months of the new contract. Participants will therefore not have access to sufficient information to make choices about which providers are best placed to meet their needs. Providers will also be disadvantaged by limited information on how competitors are performing, although they will likely retain their advantage over consumers in terms of labour market information and the DES system more broadly (Considine et al., 2018; McDonald & Marston, 2008).

Prior to the reforms, DES providers were referred a market-share of participants, with payments weighted towards servicing of participants, alongside payments attached to various employment outcomes achieved. This funding arrangement was criticised as hindering competition (as providers didn't need to attract participants to attract funding) and leading to risk selection behaviour often referred to as 'creaming and parking', whereby providers focus attention on easier to place participants in order to maximise financial returns, while providing minimal service to others perceived to be less likely to achieve employment outcomes (Nevile & Lohmann, 2011 pg.3; Perkins, 2008). To address this, the current reforms introduced a new 'risk-adjusted funding model', weighting funding on complexity of clients away from servicing and towards outcomes achieved (DSS 2017a). There is, however, a risk that service funding will be insufficient to adequately support participants with multifaceted barriers to employment, reducing the incentive of providers to take on complex participants. In turn, this may reduce choice of providers for those participants willing and able to cater to their needs (AFDO 2014). Further, providers do not always survive such conditions, with larger organisations often having more financial resources available to endure reforms, or indeed acquire smaller organisations that may be struggling to remain viable under changes to funding arrangements (Glendinning, 2008). This is evident within the mainstream employment services system (known as *job active)* and other quasi-markets for people with disabilities whereby, contrary to the objective of marketization, there has been a decreasing number of providers sustained overtime, reducing options for participants and decreasing competition (Glendinning, 2008; McDonald & Marston, 2008).

Finally, increasing participant choice and control within DES seems paradoxical to the increasing conditionality placed on welfare recipients, including threat of financial sanctions (Australian Government, 2018). Similar to other liberal welfare states, the argument for compliance is weaved into the discourse that welfare is no longer an unconditional entitlement, but dependent on individuals actively engaging with employment services to remain in receipt of income support. Pressure on welfare recipients to not burden the system, to take responsibility to work and contribute is consistently reinforced in Australia (DSS 2017a; Marston et al., 2016; Nevile, 2008). Based on her research, Nevile (2012) questions whether participant choice is possible within a system where most individuals engage involuntarily through ever-increasing mutual obligations attached to income support. Similarly, Beck (2018) in her UK research with people experiencing long-term unemployment, found choice was undermined by activation mechanisms and sanctions implemented under workfare policies. Others, such as Slade and Longden (2015), argue that despite these measures, high rates of unemployment for people with disabilities persist, as 'Welfare-to-Work' measures often implemented through NPM-inspired mechanisms continue to disregard broader underlying structural barriers to employment (e.g. discrimination, limited supply of suitable jobs) (Slade & Longden, 2015). This paper contributes to this debate by focusing on the role of consumer choice within DES reforms. Importantly, it does this through analysing narratives of DES participants with psychosocial disability on whether they exercise choice and control to stay with or change providers, exploring factors that influence both their decision making positions within the DES quasi-market and their broader access to work.

8.2 Methods

This qualitative study was embedded within a larger research project known as the Improving Disability Employment Study (IDES). IDES is implemented by the University of Melbourne in partnership with disability and employment services peak bodies and employment service providers. The aim of IDES is to improve understanding of factors that promote sustainable employment outcomes for people with disabilities. IDES involves a prospective cohort quantitative survey of approximately 350 people with disabilities currently accessing *job active* and DES providers. The survey explores well-being, socio-economic conditions, and engagement with employment services and work. Alongside the survey, this nested qualitative study aimed to more deeply explore the experiences of people with psychosocial disability currently accessing DES and how this is influenced by the reforms.

Drawing on narrative inquiry, utilisation of choice and control within DES was explored through perspectives of participants. Narrative inquiry is a methodology appropriate for exploring lived experiences of phenomena (Clandinin, 2006). It does so by eliciting underlying narratives through analysing accounts of events occurring over time and the way these accounts are told (Bruner, 1991; Frank, 2012). Narrative inquiry of the lived experience of mental illness and disability have been previously used in explorations of supported-decision making (Knight et al., 2018), self and carer conceptualisations of Autism (Gray, 2001), and experiences of recovery and psychosocial disability (Ridgway, 2001). Narrative inquiry was used by Ezzy (2000) to analyse the way recently unemployed people described their experiences as positive (with a sense of agency) or negative (influenced by external social factors). These studies demonstrate the usefulness of narrative inquiry to generate a deeper understanding of how social factors may influence individuals, their actions and ongoing experiences of phenomena (Clandinin, 2006; Ezzy, 2000; Holland et al., 2006; Riley & Hawe, 2005). Narrative inquiry can also help in exploration of how policies are experienced by different stakeholders, and evaluation of whether the purposes of policies are being achieved (Barabasch, 2018).

Narratives were drawn from 27 semi-structured baseline (n=14) and follow-up (n=13) interviews with 14 DES participants with psychosocial disability, conducted between November 2017 and June 2018. Potential participants included IDES survey respondents who: 1) identified as having psychosocial disability, and, 2) had given consent to be contacted to ascertain interest in participating in follow-up interviews. Eligible individuals were contacted by the lead researcher/author and provided with information about the study. If interest was confirmed, a time and meeting place was arranged to conduct the interview. The research team also worked with four DES providers working with participants with mental health conditions to identify additional potential participants. Staff provided potential participants with information about the study. As above, interested participants were followed up by the lead researcher. Informed consent was collected from all participants prior to each interview. All participants were 18 years or older. Across the two interviews, participants were asked to reflect on their mental health, work and broader life circumstances and how this was influenced by DES, including in relation to the increased choice and control that was intended to be made available through the 2018 reforms. Follow-up interviews also focused on changes that had occurred in their lives since the baseline interview, including specific probing regarding whether they had received information via their DES provider or in the form of a letter from the government outlining increased opportunity for choice and control in their engagement with DES. Interviews were audio-recorded and later transcribed, each lasting

approximately 45 minutes. Ethics approvals were obtained from the University of Melbourne Health Sciences Human Ethics Sub Committee (1750133.1).

Analysis began with multiple readings of each transcript by the lead researcher, initially focusing on individual narratives across the two interviews, identifying life circumstances (e.g. education, socio-economic factors), experiences (e.g. work, mental health, DES), and relationships (e.g. family, DES, within employment) given the most prominence and whether and how these changed over time (Holland et al., 2006). Examples of participant choice and control within and external to DES were identified, with the analysis examining how choice and control was perceived and positioned within and across each participant's narrative, alongside factors described as influencing decision-making. Comparisons were then made across the cohort to identify similarities and differences in whether and how participants exercised control to stay with or change providers. This was done with the understanding that narratives can be categorised as stable - a person's evaluation of an experience remains the same over time; regressive –a person's narrative of an experience gets worse over time; or progressive –a person's narrative of the experience improves over time (Gergen & Gergen, 1988; Riley & Hawe, 2005). Four main narrative positions were determined with each participant mapped to one position, providing insight into whether participants will exercise choice and control to remain or change providers, and, factors that may influence this process under the reforms.

8.3 Findings

Adverse life circumstances that undermine access to work and capabilities for choice and control were a common theme of all interviews. Difficult upbringings, family breakdown, disrupted education, unemployment, traumatic events (e.g. sexual violence, military deployment), poor physical health, homelessness, and, significant financial hardship, intertwined to influence mental health, engagement with DES, and the ability to find and keep work. However, the extent that these broader life circumstances were emphasised as constraining participants' capabilities for exercising choice and control within and external to DES varied, as did the countering sense of empowerment to engage in the labour market. Yet, efforts to independently secure work proved elusive for all but a few, particularly when challenging life circumstances were compounded by limited availability of jobs that fit with skills, needs and aspirations, alongside, discrimination and lack of opportunity to engage with employers. So, while more than half of participants accessed DES voluntarily, all participants spoke of DES as an inevitable necessity, rather than something they were engaging with out of choice or because of mutual obligations.

Within this context, and noting no-one had actively exercised control to change providers, the narratives clustered across four different positions illustrative of whether participants exercise choice and control to stay with or change providers: 1) *Actively choosing to stay;* 2) *Passively staying;* 3) *Reluctantly staying;* and, 4) *Tinkering on the edge of change.* Factors influencing positions included level of satisfaction with their current provider, often compared with past experiences and expectations of whether and how providers could work with participants to achieve employment expectations; mental health and availability of supports to address mental health and other health concerns; and, broader life circumstances. The findings below outline the socio-demographics of the cohort before describing these four narrative positions.

Socio-demographics of participants

Participants were between 21 and 48 years of age, with most identifying depression and/or anxiety as their main mental health condition. Educational outcomes varied across the group (See Table 8.1). Eight participants were voluntary job-seekers, whilst six were mutually obligated to engage with DES. Four participants were working part-time at baseline but were required or aspired to gain more hours. Eight were unemployed and not volunteering, and two were volunteering but hoping to gain paid employment. At follow-up, one participant was unable to participate. In terms of employment status, seven remained unemployed and not volunteering, four were unemployed and volunteering, one was working part time, and two were working full time. Ten participants were still with the same provider, with three in the process of changing providers as their current provider no longer held a contract to provide services after the reforms.

Table 8.1 Baseline participant demographics

Variable		Total N=14
Age	Average	36.7 years
	Range	(21-48yrs)
Gender	Male	8
	Female	5
	Gender non-binary	1
Country of birth	Australia	13
	Other	1
Geographic location	Urban/Semi-urban	8
	Regional/Rural	6
Education	Did not complete secondary education	3
	Completed secondary education	3
	Completed TAFE qualification (e.g. Diploma)	3
	Currently undertaking post-secondary qualifications	3

	Completed tertiary education (e.g. Bachelor)	2
Self-reported mental health condition	Depression and/or Anxiety	9
	Post-Traumatic Stress Disorder	2
	Schizophrenia/Psychosis	3
Welfare Support*	Disability Support Pension	6
	Newstart Allowance	4
	Sickness Allowance	1
	Job Seeker Allowance	2
	No income support	1
Job seeker status	Voluntary	8
	Compulsory	6
Employment status	Unemployed	8
	Volunteering	2
	Working part time but needing more hours	4
	Full-time	0

* Welfare support in Australia includes various pensions and income support payments for people who are unemployed. Income support payments generally have mutual obligation requirements attached, i.e. recipients are obliged to actively look for work.

8.1.2 Narratives on choice and control

1) Actively choosing to stay

The reasons why people actively chose to stay with their current provider were multi-faceted, influenced by satisfaction with support received, achievement of employment outcomes, and, a reluctance for change. Similar to the cohort more generally, people in this group had experienced adverse life circumstances, but were currently relatively stable in relation to their mental health, housing, and family support. They were positive about the role that the right job could play in their lives and were proactively working with their provider to find work.

> *When I know I am doing really well at work, it makes my mental health almost better, because I know I'm helping people. I am helping customers, my manager is really happy with me. I am getting money for doing this. Like every aspect is going good, when things are going well in that section* [work] … *Like for my mental health, like it really brings it back up. But as I said, it's hard finding jobs like that.* (Participant #6, a-baseline interview (P6a))

Participants remained positive about the service they were receiving across the two interviews. This was facilitated through resourced in-take processes and matching with employment consultants participants felt were skilled, knowledgeable of local labour markets, and, empathic to their circumstances. The sense of social connection gained through engaging with their provider also contributed to a willingness to stay, especially for people with limited social networks. Levels of

satisfaction were often spoken of in comparison to previous experiences with the mainstream *jobactive* program, or, years of unsuccessfully navigating the labour market independently. Indeed, one participant had considered dropping out of the welfare system altogether rather than further endure the stress of *jobactive*. They had been unaware of DES until recommended there by a family member.

> [*jobactive* provider] *actually became so stressful and such a burden, that I stopped going to Centrelink* [Australian welfare interface]*. I was just going to tough it out, I just couldn't deal with it anymore … Just little things, like they ask you to report, but half the time the reporting system is down. It's just a nightmare. I wish it was just more nice … But* [*jobactive* provider] *and places like that, you are just a number. Like you are a burden, it sounds really bad but I felt like a dero*[/elict] *walking in there. Because that is how they were treating me. Like 'you're just a person that doesn't have a job'… I was just really wanting some extra help and support as I was a bit lost and didn't know what I wanted to do. And also having trouble with my dyslexia and mental health, as my mental health really affected my last job. So Mum suggested to come down to speak to* [current DES provider] *and I did and they have been absolutely fantastic. I am so happy I did.* (P6a)

People in this group felt they had been directly supported by their provider to achieve employment outcomes. Outcomes included paid work or incremental steps towards this. Finding voluntary work for example, contributed to a self-belief for participants that paid work was possible, which in turn promoted mental health.

> *Before I got the* [volunteer] *job it was a big issue getting work. Like a lot of people put me down because I wasn't working … Like people give a lot of importance to work. Before it was a big mountain on me that I can't work and I was trying to analyse that …. I was negative about it, that I can't work, it's too much for me. But now it's become less of an issue. I became more happier. More relieved that that big problem, I've addressed it, and now it's moving, and that's how it's helped my mental health.* (Participant #2, b-follow-up interview (P2b))

For individuals that found work, appreciation for help received, alongside a need for ongoing support to navigate the workplace, and, a desire to further progress career aspirations kept them engaged with their provider: 'And that is why I'm still trying to stay in touch with them. As much as I love this job, I really want a job helping someone, where it's very rewarding in that sense. Or something that is very different every day. I would love to do casework.' (P6b). In comparison to other positions, this position was characterised by a resistance to exercising choice and control both

within and external to DES. Some did not want to have control over their every-day decision-making including in relation to work, extending this to wanting more government support to make decisions within DES.

> *Every little decision in my life, like I will always ask my mother and my grandmother, and then of course my partner … But I will ask anyone and everyone. I am just that sort of person that likes to ask for advice, and be reassured that what I'm doing is the right thing … I don't want control … It would be nice if Centrelink and that gave advice on what would be the best job provider for you.* (P7a)

There was also a perception that 'experts' know best and the decision around which provider to go to should be made by these 'experts', questioning whether people with disabilities should be afforded choice and control within DES.

> *I received a letter from the government saying about choice and control, in choosing another provider, and I spoke to* [DES consultant]*, and she said 'Yes from 1 July people can choose their DES provider'. She asked me what I thought about that. And I said I think it's a bad idea …. Because why I think like that? Because people when they go to Centrelink they don't know where to choose. Like each individual is suitable for a particular agency. Like they know at Centrelink. They know from your history and from talking to you ... If people start choosing for themselves … like which agency, they don't know, they just think about the area …. And I said to* [consultant]*, like people who want to avoid work … like involuntarily made to look for work, they will be choosing an agency that will be soft with them, but now they can't. They have no choice.* (P2b)

2) Passively staying

People passively staying with their current provider were more focused on trying to improve their mental health and address challenges in their broader lives, placing less priority on or feeling less confident that work would be beneficial or even possible in their current circumstances. Indeed, accounts of negative workplaces experiences including exploitation and bullying were commonly accompanied by dialogue on the detrimental impact these experiences had on mental health and work confidence: 'Like there was the odd one, like weekend sort of jobs. But I just haven't been, to be honest, I haven't the confidence to apply after what happened at [previous workplace], I'm scared.' (P12b). There was a recognition in this group that when choice and control over the type of work undertaken had been undermined either by the system or life consequences, it created a cycle

of accepting inappropriate jobs, impacting on mental health, employment outcomes, and, subsequent confidence for work.

> *I just go for any job because it's there, because I just need a job. That's why I've had so many jobs, because it's just really stressful the ones that I go to … You always have to be careful with Centrelink. They are always trying to kick you off it. That is the other thing I suppose, some of them who might not be capable, might be forced to work. So it's* [choice and control] *a bit of a contradiction of statements.* (P12a)

This however did not equate to proactively seeking out a provider that may be more effective or supportive in finding them suitable employment. If the relationship with their provider was not negatively impinging on their mental health or if there was social value perceived in the connection with the provider (or other incentives), exercising choice and control to change providers seemed somewhat irrelevant, even if they recognised they were not feeling well supported to find work: 'The interactions with [consultant] have been positive. Because although I didn't always feel that I was helped in terms of my job searches, in terms of my mental health it was good when she talked to me.' (P12b). There was also a sentiment that all providers (and employers) are the same so there was little point in changing.

> *Why would I change? These people are 'yes come to us and we will do this'. And then they deliver nothing. Where is the incentive to even look into it? When I already know, based on my own experience, nothing works, so why would I change?* [Interviewer [I]]: So what do you think makes you stay? [Participant [P]]: *Because they are the better of two evils* [I]: And you're still hoping the situation will change and they will help you find work? [P]: *No. The only person that is gonna help is me. This is just another example of a failed system … And so I still go there and he gives me $20 every time I go. So that is an incentive. I say that rather cynically as well … But he is another person that I speak to. And so another person who can say, 'Well we can just generally agree* [P9] *is still sane today. A little bit twisted, but somewhat sane, for the most part he still is sane, yes?'* (P9b)

This group often had low expectations of the level of support they felt they deserved within DES and their broader life. In turn they were less likely to think they had the right to change to a provider which may provide more support.

> *I was going to but I don't know, I just kept going with the flow. I would feel bad. And I thought my case worker here was mad at me. So I thought I would be running away from it I guess. Because when I overdosed at work I came here, because I didn't know what else to do*

> *… I think anywhere I go is kind of the same. I think people think you are capable of doing things yourself. They don't think you really need help.* [I]: Do you think people think you are capable of doing it yourself? [P]: [Nods] [I]: And you feel therefore they don't offer you as much help? [P:] *Maybe. I just try and do it though. Because there are people who can't read or write. I just need to get past the* [guilt]. (P12a)

If changes were required, for example if a provider lost their contract, these participants recognised they had the right to choose a new provider, but were content for Centrelink to make this decision for them. The prospect of changing providers if they weren't happy in the future was again spoken of with aversion and scepticism of being supported to attain work accommodating of their circumstances.

> *Yes so it's an automatic default. So Centrelink would have chosen that one anyway, so it is easiest to go there … I'll probably just stick with them until I get a job … They'll probably force me into the position where they want me to work. I'm sure that it'll be fine.* (P10b)

3) Reluctantly staying

Some individuals were staying with current providers despite articulating deep dissatisfaction and a recognition that staying was not leading to employment, and, was detrimental to their mental health. Their evaluation of engagement with their provider consistently deteriorated over time: 'I just hate coming here now … I don't know what my options are. I'm not even sure she has looked at my CV. Like I don't even think she knows that I'm a [profession]. I don't think she knows anything about me.' (P7b). This narrative most often was grounded in an overwhelming confluence of limited availability of suitable jobs, hostile life circumstances, and hindered capability for choice and control. Paid employment was therefore seen as essential to improving life circumstances as well as promoting choice and control over their lives, yet work remained unattained.

> *I can't even meet Maslow's hierarchy of needs, like in terms of safety or shelter … it impacts on your mental health and impacts on your physical health. …* [I]: And then the way forward in terms of gaining more choice and control? [P:] *I suppose having a job. Having financial solutions available that are available to 90 per cent of Australians … It is probably not something I will see in my lifetime.* (P1a)

Self-belief in capability for choice and control had often been undermined by limited support to foster independence and low expectations for decision-making across their life course: 'She [mother]

didn't give me the tools to live independently, like emotionally … I was completely controlled … I wasn't allowed an opinion. I would get yelled at for speaking up about anything.' (P3a). Further, choice and control over educational and career aspirations had regularly been disrupted by family and broader structures.

> *I always have these opinions from everyone … There was a point where I wanted to go to TAFE* [Technical and Further Education]*, because maybe I will do horticulture, because I love being outdoors ... 'Oh you won't like that, oh you won't like being in the sun all day or being on a tractor.' I am like, well how do you know unless I try … let me take a chance. I feel like I've always been the one that they control … I don't think they trust the choices I will make.* (P5a)

Circumstances for people in this group generally worsened over time. Persistent unemployment meant they were still unable to access appropriate housing or address health conditions, further hampering efforts to look for work. Some providers did try to address some of these non-vocational barriers, but with limited success.

> *Nothing is improved, I feel worse than I did the last time I saw you … I just don't have the money to go to an Osteopath or go to a Physio … or do Pilates or anything like that. It's so expensive. So I haven't. It seems to me like a Catch-22. Like I need to do it to improve my back, but I don't have the money to do it. And then I just kind of sit down and go, I can't do it.* (P7b)

> *I would very happily go to a boarding house if it was a safe space. But my experience of two boarding houses, I've had my car stolen and I got bashed by a woman in another … It really feels like a battle sometimes. Like I stopped working because of this health problem two years ago, because I don't have permanent accommodation … I really just don't know how people with disabilities are supposed to find employment when they don't have safe housing. … And* [DES consultant] *really made me go to* [Housing service] *and that was just humiliating, exhausting. I have done it ten times before.* (P1b)

These narratives emphasised ongoing barriers within the broader welfare system influencing choice and control before and during engagement with DES. Participants for example described difficulty accessing DES due to gaps in the referral process: 'I had been ringing Centrelink since March, twice a month to get a provider, and they just didn't respond. Until I rang a provider directly, and they contacted Centrelink … I knew I was eligible for services, they just wouldn't put in the referral.' (P1a).

Reasons for not changing providers (unless forced to due to DES closure) were linked to limited knowledge on how to change or what other services were available.

> [I:] If [new provider] don't turn out to be as good as you are hoping, will you change? [P]: *If I have to I have to, I guess.* [I]: But if you don't have to you won't? [P]: *I won't.* [I]: You won't because it's hard to change or? [P]: *I honestly hated it here* [I]: But you didn't change? [P]: *I didn't think I could* [I]: But now that you know you can? [P]: *I hopefully wouldn't hate it because I think there is only here or there.* (P11b)

Even when external supports (e.g. mental health workers) could also recognise that individuals were not being provided with adequate support and their mental health was being negatively impacted by this, these participants still felt a reluctance to change providers. Often the thought of rectifying the situation by engaging with Centrelink and re-telling their story to change providers, or to change their work requirements was too overwhelming. A compromise for some was to change consultants within the same provider.

> *I don't know what changing providers will do. Like I said it's a situation the employers have the control and they want things to be their way … When I spoke to my psychologist, he was like 'You look pretty overloaded with stuff and really should be on maybe a seven hour requirement'. He said 'go back to Centrelink' and I haven't. And I thought about it but I am just like, I don't really wanna go there. The feeling of having to explain to them, and feeling like they aren't going to listen and I will get angry … I haven't had the energy to go down and do that.* (P13b)

When this sense of hopelessness was intensified by unemployment, rather than change providers, some people in this group requested a suspension from job-seeking or left DES: 'I just gave up looking for work, because I don't have anywhere to live'. (P1b). For others, a combination of negative treatment by DES staff and persistent unemployment, meant that leaving DES altogether was seriously being contemplated. Not only were people in this narrative giving up on DES, but giving up hope that finding a job was possible.

> *My previous worker actually said to stop telling people I have cerebral palsy. I said I don't want to do that because I don't want to walk into interviews and for them to get me out because I am disabled. I would rather be above board, and for* [DES provider] *to say this person is disabled but she can do so much… My previous worker also said 'Don't focus on the animal care thing because there is not much employment out there'. I said okay but I have*

always been going for different jobs … I thought that I would have got a slightly higher level of service because I'm here on my own volition … They therefore should be looking at me like 'She is an enthusiastic job seeker.' Rather than being forced to be here. So I thought that I would get a bit more help, but it doesn't seem to be. I'm not given much help at all. [I:] And then in terms of going elsewhere, would you look for a different provider? [P]: *I don't think I would go with another provider at this point if I left … I don't know, I haven't really had much luck with providers.* (P3b)

4) Tinkering on the edge of change

People in this position were the most proactively talking about change. For this group, enhanced choice and control within DES was seen as a positive thing: 'I think they should feel like they are not locked in, like they don't have to be here if they don't want to be here. Sometimes I think these places, people think they are being punished to go.' (P8a). Their lives were characterised as stable with relatively secure accommodation, supportive family and social networks, and happy enough with their mental health support. Individuals were motivated to work and were proactively engaging with the labour market, but were yet to find work. Empathy with and not wanting to offend their DES worker or avoiding the potential confrontation that changing providers may cause, seemed to be the main reason these participants were yet to change.

I think I'm probably going to change to be honest. When I came here I had originally heard good stuff about it, and I don't know, maybe I was reluctant for change, or also, I tend to not be so pushy … and I also want to give another chance … I mean on the other side of things, I mean a lot of them have to deal with people that just don't want to find work and that can be a bit demoralising as well. (P14b)

For this group, access to paid work was spoken of as the only thing missing in their lives, as well as a much needed means of income. Whilst identifying frustrations, their relationship with DES was generally spoken of positively. Frustrations included high turnover of staff and the financial burden of going to appointments, but predominantly they stressed that outcomes were not being achieved, and a fear that persistent unemployment would undermine their mental health and life circumstances. Yet, they still seemed willing to give their DES provider at least one more chance: 'I don't want to make anyone feel like they have failed. I don't wanna hurt anyone's feelings. But I know I have to look after myself and it's about me getting work.' (P8b).

Participants described positive family support which helped them exercise choice and control across their lives: 'I think I'm getting there, I mean I want to get advice from my parents, like even before

the schizophrenia.' (P14a)**.** Participants recognised that this family support alongside support from mental health services would be needed to help them feel ok about changing, as well as support them to access another provider or different types of supports. Indeed, some had already begun the process of drawing on other mechanisms to find work and felt that these alternatives may prove more effective than staying with or changing DES providers.

> *I'm going to look elsewhere and also try and reach out to maybe other career seekers. So I have been talking to* [mental health service] *as well now … I imagine I have to go on the Internet and find out myself. I mean, my mum is often looking for me and looking around because she works with lots of kids with psychosis … and men, women with psychosis. She has kind of got a good idea of the ones that have had a huge success rate. …, so that is definitely a consideration I guess. I have stuck with* [current provider] *for a while. I have wanted it to work but you know, the turnover rates are just astounding.* (P14b)

8.4 Discussion

The NPM-inspired reforms to the DES program follows a trend established by many governments to introduce consumer choice into the marketization of welfare services, in an effort to make services more responsive to consumer needs and more efficient and effective in delivering outcomes (Aberbach & Christensen, 2005). Our findings however resonate with the concern raised by other NPM commentators: that such reforms rely too heavily on the assumption that all consumers are equally capable and rational in exercising choice and control and that markets are well-functioning and resourced to respond to the signals and varied needs of consumers (Clarke et al., 2005; Jilke, 2015). There appears to be limited recognition of the complex factors that influence choice and control, particularly for consumers in need of or compulsorily engaged with services within disability and welfare quasi-markets (Clarke et al., 2005; Glendinning, 2008).

The key finding in this study highlights participants will not necessarily exercise control to choose or change DES providers when afforded more opportunity to do so in the context of the current reforms, even if they are dissatisfied with the service they are receiving and recognise that employment goals are not being achieved. Participants across the four narratives varied in their capabilities and willingness for choice and control within and external to DES. However, all narratives overwhelmingly voiced the multifaceted challenges encountered in exercising control to both enter and move within the DES quasi-market. Similar to the decision-making influences observed in other quasi-markets, this was influenced by the interaction of their life circumstances, particularly co-

existing health conditions, access to housing, availability of formal and informal support, their previous experiences with services, the fluctuating nature of mental health, and their satisfaction with their current provider (Glendinning, 2008; Van de Walle & Marien, 2017).

Yet each narrative offers different propositions on how providers and the DES program may respond to the varying needs and capabilities of participants and better support all participants to exercise more choice and control both within and external to the market. Participants' *'Actively choosing to stay'* with their current provider, for example, valued support received from the provider. This was linked to positive intake processes and matching with suitable consultants, as well as support in relation to accessing work. Yet individuals in this group seemed to be overly reliant on the knowledge of 'experts' and others to make decisions, not only on engagement with DES and the labour market, but more broadly across their lives. Support to develop skills and self-belief in their decision-making would therefore be of real benefit to these participants both within and eternal to DES (Parent, 1996). Such support would equally benefit individuals *'Tinkering on the edge of change'*, yet participants in this group also require more external support to feel confident in their right to exercise their desired choice and control to change providers.

As has been observed within NPM research elsewhere however, barriers within referral processes and limited information and knowledge on the availability and performance of providers, undermined capacity to differentiate and proactively choose between services. This was particularly an issue for participants who were passively and reluctantly staying with providers as they perceived there was little to differentiate between these, so saw no point in exercising control to make a potentially stressful change. Consumer choice within the marketization of public services relies on effective market stewardship (Carey et al., 2018). DSS, as the responsible government department overseeing DES, need to more effectively respond to this current gap and improve participants' access to appropriate information and support to enable informed choice and control. As market stewards, DSS also need to monitor the actions of consumers and providers to understand how reforms are influencing the effectiveness of the DES quasi-market.

Participants who were '*Passively'* and *'Reluctantly'* staying with providers were most readily able to identify persistent issues within the supply-side of the market that DES providers, DSS and the broader government need to be much more adept at responding to. Low expectations of participant capability and the disregard of job requirements, skills and career aspirations of participants continue to hamper sustainable job placements. This undermines both work confidence and longer-term career development, as well as negatively impacting on mental health. High turn-over of staff was also reported as a concern due to the loss of continuity of support. Many participants had

endured exclusion and discrimination in their lives. In some circumstances providers were helping to meet a participant's social needs and were seen as part of their support network, so whilst they may not be effective in helping people find work, providers were at least viewed as a connection to maintain. This was particularly so for individuals within the *'Passively staying'* group, but also seems to contribute to a fear of confrontation that may be precipitated by requesting to change providers, and also a sense among individuals and participants *'Tinkering on the edge of change',* that they did not want to cause emotional harm to frontline staff. This empathy however meant some participants were less likely to change to a provider that may have been better placed to support them into work. Similarly, many participants had lowered expectations of their rights to receive support or to find suitable work, and thus a reluctance to speak out when employment goals were not being achieved. Similar to experiences reported with other systems, such as individualised disability budgets in the UK, there was also participant reluctance to change providers due to not wanting to tell their story again (Glendinning, 2008).

As in other studies such as those by Crozier and Muenchberger (2013) and Sweeney et al (2018), participants' life circumstances encompassed previous trauma, negative experiences of employment services, housing insecurity, poverty, lack of informal support, and insufficient access to health services. These factors not only influenced mental health, but how people engaged with their DES provider and their desire and capability for exercising choice and control both within and external to the DES system. The difficult life circumstances of many people with psychosocial disability can compound the impact of unemployment and lead to a pattern of learned helplessness, making it more difficult for people to optimistically or proactively respond when employment support is offered (Harumová, 2016). Promoting trauma-informed practices within DES (e.g. supporting stable and trusting relationships that recognise the impact of past trauma) is therefore important to prevent re-traumatisation of service users and better support participants whose life circumstances may have undermined their decision-making capability (Sweeney et al., 2018). Of concern at a more structural level however, is that increasing marketization of DES does not enable the challenging life circumstances of participants with psychosocial disability, that greatly influence access to work and capabilities for choice and control, to be addressed. Drawing on Clarke and his critique of the utility of consumer choice theories within public service reforms, this highlights that these markets are often not resourced to appropriately respond to the complex needs of consumers in need of welfare services (Clarke et al., 2005).

Compounding this is the expectation that choice and control will be exercised within a system where most participants are compulsory engaging with DES under mutual obligations to remain in receipt

of income support. While participants generally did not object to their own mutual obligations, perspectives on whether other people with psychosocial disability should be obligated to engage with DES reiterated that people should have more control over this process. Concern centred on an inherent tension in making people with psychosocial disability involuntarily look for work, as the stress of mutual obligations may exacerbate their condition. Similarly, participant storylines were often entwined with, yet resisted, wider discourses around welfare recipients. Heavily influenced by NPM, such discourses emphasise the centrality of work to citizenship, blaming individuals for their unemployment and expecting them to adapt their behaviour to be able to fit into labour markets (Howard, 2012).

Participant narratives consistently confirmed that people don't choose to be unemployed or in need of welfare. When they do experience these circumstances however, the system established to provide support can actually compound their hardship, through negatively influencing self-worth and contributing to negative perceptions around employing people experiencing long-term unemployment (Howard, 2012; Schofield & Butterworth, 2018; Slade & Longden, 2015). In this regard, it is therefore difficult to envisage DES participants as consumers that can choose to exit, as consumers in private markets may do. The only way to exit DES is to find sustainable work, or for people over the age of 35 years to gain access to the Disability Support Pension, both of which are proving increasingly difficult for people with psychosocial disability to achieve (NMHCCF 2011; Parliament of Australia, 2018).

For participants across all positions, their experience in DES continued a pattern of having their educational, career and life aspirations undermined and their capability for independence neglected. As highlighted by Brophy et al (2014) it remains fundamental when promoting choice and control within marketized social policies, to recognise the capacity of people with psychosocial disability to make decisions about their own lives, albeit that some people desire and require support through processes such as supported decision-making (Brophy, Bruxner, Wilson, et al., 2014; Knight et al., 2018). DES have an essential role in ensuring participants are supported to exercise choice and control. While these reforms are relatively new, this requires providers to better enable participants to develop and draw on formal and informal support networks to not only support decision-making, but also to enhance self-belief in their capacity to work (Shaw et al., 2004). This however requires greater recognition and resourcing of processes that support decision-making and contribute to building support networks. In the absence of system level data on how the DES market is performing, it also requires providers to open themselves up to evaluation by their participants, and actively listen to the perspectives of participants on how services could be improved. Not only would

this support the empowerment of participants to exercise choice and control, but would also support services to be more responsive to the diverse needs of the consumers they serve (Clarke et al., 2005).

8.5 Conclusion

Acknowledging the limitations of this study, insofar as interviews were completed just prior to the implementation of the July 2018 DES reforms, the narrative positions outlined in this paper usefully propose four potential ways DES participants may more broadly respond to the prospect of increased choice and control within the context of the current reforms. Further research at a point when the DES market has had more time to respond to the changes could test the validity of these positions as well as help DES providers and market stewards understand how to empower and support diverse individuals to more actively exercise choice and control within and external to the DES market. However, it remains unlikely that the choice and control afforded to participants under the latest marketization of DES, will alone lead to improved competition and effectiveness of DES and subsequent employment outcomes for people with psychosocial disability. This in part is because of the multitude of factors within DES which influence participants' willingness and capability to exercise control to change providers, but is equally influenced by factors external to DES.

An effective DES system that relies on marketization, can only exist within a broader context of policies, programs and environments that more effectively address the challenging life circumstances often experienced by this cohort (e.g. access to affordable and accessible housing, a history of trauma, poor mental health care), as well as structural barriers to employment such as disability-related discrimination and the limited number of jobs that fit the skills, aspirations and needs of the growing number of people with disabilities wanting (and mutually obligated) to find and maintain meaningful employment. Instead of investing so heavily in NPM inspired DES reforms, governments need to be doing more to address these structural barriers if they do really want to improve the mental health, employment outcomes and life circumstances of people with psychosocial disability.

Chapter summary

This chapter explored the perspectives of DES participants on exercising choice and control within the context of DES. It highlighted participants will not necessarily exercise control to choose or change DES providers when afforded more opportunity to do so, even if they are dissatisfied with the service they are receiving and employment goals are not being achieved. Individual capabilities and willingness for choice and control within and external to DES vary, yet were commonly influenced by broader life circumstances, such as the compounding nature of poor mental health, unemployment, and, welfare systems that are often not able to meet the needs of people requiring (or obligated to use) them. The following chapter examines how factors such as these, influence the mental health and personal recovery trajectories of DES participants with psychosocial disability.

Chapter Nine: 'I'm proud of how far I've come. I'm just ready to work'

This chapter synthesises IDES Wave 1 quantitative survey data exploring factors that influence the mental health and well-being of IDES respondents with psychosocial disability, with, a narrative analysis of personal recovery in the context of DES, using data from the 56 qualitative interviews. As such, the chapter responds to research questions 1-3 and 5, by examining how the life circumstances, and, mental health and well-being of DES participants with psychosocial disability, are influenced by and in turn influence, their engagement with DES. The chapter includes a paper accepted for publication in *BMC Public Health* 20, 325, March 2020, https://doi.org/10.1186/s12889-020-8452-z. .

***'I'm proud of how far I've come. I'm just ready to work'*: mental health recovery narratives within the context of Australia's Disability Employment Services.**

Authors: Alexandra Devine[a], Cathy Vaughan[a], Anne Kavanagh[a], Helen Dickinson[b], Sean Byars[a], Stefanie Dimov[a], Bill Gye[c] and Lisa Brophy[d,e]

[a] *Centre for Health Equity, Melbourne School of Population and Global Health, University of Melbourne*

[b] *Public Service Research Group, School of Business, University of New South Wales*

[c] *Community Mental Health Australia, Sydney, Australia*

[d] *Centre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne*

[e] *Social Work and Social Policy, School of Allied Health, Human Services and Sport, La Trobe University*

Abstract

Background: Employment is recognised as facilitating the personal and clinical recovery of people with psychosocial disability. Yet this group continue to experience considerable barriers to work, and, constitute a significant proportion of individuals engaged with Disability Employment Services (DES). Recognition of the role of recovery-oriented practice within DES remains limited, despite these approaches being widely promoted as best-practice within the field of mental health.

Methods: The Improving Disability Employment Study (IDES) aims to gather evidence on factors influencing employment outcomes for Australians with disability. Descriptive analysis and linear

regression of IDES survey data from 369 DES participants, alongside narrative analysis of data collected through 56 in-depth interviews with 30 DES participants with psychosocial disability, allowed us to explore factors influencing mental health, well-being and personal recovery within the context of DES.

Results: Psychosocial disability was reported as the main disability by 48 per cent of IDES respondents. These individuals had significantly lower scores on measures of mental health and well-being (44.9, 48.4 respectively, p≤0.01), compared with respondents with other disability types (52.2, 54.3 p≤0.01). Within this group, individuals currently employed had higher mental health and well-being scores than those not employed (47.5 vs 36.9, 55.5 vs 45.4 respectively, p≤0.01). Building on these findings, our qualitative analysis identified five personal recovery narratives: *1) Recovery in spite of DES; 2) DES as a key actor in recovery; 3) DES playing a supporting role in fluctuating journeys of recovery; 4) Recovery undermined by DES; and, 5) Just surviving regardless of DES.* Narratives were strongly influenced by participants' mental health and employment status, alongside the relationship with their DES worker, and, participants' perspectives on the effectiveness of services provided.

Conclusion: These findings re-iterate the importance of work in supporting the mental health and well-being of people with psychosocial disability. Alongside access to secure and meaningful work, personal recovery was facilitated within the context of DES when frontline workers utilised approaches that align with recovery-orientated practices. However, these approaches were not consistently applied. Given the number of people with psychosocial disability moving through DES, encouraging greater consideration of recovery-oriented practice within DES and investment in building the capacity of frontline staff to utilise such practice is warranted.

Key words: personal recovery, mental illness, psychosocial disability, Disability Employment Services

9.1 Introduction

People with psychosocial disability are a sub-group of people whose experiences of mental illness (e.g. depression, anxiety, schizophrenia), in interaction with the socio-cultural context (e.g. norms around mental illness, stigma, availability of supports and services) in which they live, have led to disabling experiences (NMHCCF, Harvey et al., 2016; Hayes et al., 2018; 2011). Socio-economic inequalities and poor health outcomes experienced by people with psychosocial disability are both causes and consequences of their poorer employment outcomes. Their labour force participation

(29%) and unemployment rate (19%) in Australia for example, are poorer in comparison to people with other disabilities (53.4% and 10% respectively), and substantially lower than the general population (83.2% and 5%) (ABS, 2016; DSS, 2016b; Harvey et al., 2016).

As in many Anglophile countries, recovery-orientated practice is one of the key principles guiding Australia's mental health system to support the personal recovery of people with mental illness to 'create and live a meaningful and contributing life in a community of choice, with or without the presence of mental illness' (COAG, 2017, p. 69). Personal recovery can be distinguished from clinical recovery in being less focused on symptom reduction and more focused on well-being and having a flourishing life. Recovery-orientated practice aims to deliver services that recognise the uniqueness of individuals, empowering them to make choices about what recovery means to them and how they want to engage with services and receive supports that facilitate their personal goals (Farkas et al., 2005; Le Boutillier et al., 2011; Mental Health Standing Committee, 2010; Slade, 2010).

Employment is widely recognised as facilitating both personal and clinical recovery (Slade & Longden, 2015). Many people with psychosocial disability, however, continue to experience vocational (disrupted education and work histories) and non-vocational (discrimination, limited social networks) barriers to employment and often require support to attain employment (Simonsen et al., 2013). The Disability Employment Services (DES) program is the Australian Government's specialised welfare program for people whose disability is assessed as their main barrier to employment (DSS 2015b). Of the more than 273,000 current DES participants, 41.0 per cent are reported to have a 'psychiatric'[12] disability as their primary condition (DSS 2019b), and, employment services were the most commonly reported non-residential service accessed by the 100,866 people with psychosocial disability receiving supports provided under Australia's National Disability Agreement (NDA) during 2017-18 (AIHW, 2019b). Recovery-orientated practice however is absent from Government documentation pertaining to DES, with its overarching objective stated as being *'to improve the nation's productive capacity by employment participation of people with disabilities, thereby fostering social inclusion.'* (DSS, 2018a, p. 11).

This paper explores how DES participants with psychosocial disability experience recovery. The paper begins by discussing the relationship between mental health and work, exploring conceptualisations of recovery and recovery-orientated practice. A description of the IDES quantitative and qualitative methods follow. Quantitative findings examining the mental health and

[12] DSS refer to psychiatric disability as opposed to the author's use of psychosocial disability.

well-being of IDES respondents and factors which influence these measures are presented. We then describe the recovery narratives emerging from narrative analysis of the qualitative interview data. Lastly, we integrate study findings to discuss how mental health, well-being and recovery are influenced by engagement with DES, work and systems-level challenges, and, discuss approaches for improving employment support and recovery outcomes for DES participants with psychosocial disability.

Mental health and work

People with psychosocial disability often experience exclusion across various life domains, contributing to socio-economic disadvantage in education, housing, employment and social participation. This disadvantage in turn influences health. When health needs are not met, mental health conditions are often exacerbated, compounding barriers to employment (Bird et al., 2014; 2011; Simonsen et al., 2013).

Substantial evidence highlights the importance of work in facilitating both clinical and personal recovery (Bush et al., 2009; Slade & Longden, 2015; Suijkerbuijk et al., 2017). Work supports an individual's economic security and improves standard of living. This in turn facilitates access to factors that inherently support physical and mental health, such as housing, transport and recreation. Work helps to provide structure to people's daily lives, as well as contributing to a person's sense of self and social connectedness (AHRC, 2016; Kavanagh et al., 2016; Milner et al., 2014). Previous research has also found work plays a central role in recovery by encouraging people with mental illness to develop strategies to manage their symptoms (Dunn, Wewiorski, & Rogers, 2008).

Mental health can be negatively impacted, however, if work is of poor psychosocial quality (Butterworth, Leach, McManus, & Stansfeld, 2013; Milner et al., 2019), such as when people are exposed to hazardous conditions or when tasks do not match skills, interests, or remuneration. Workplace bullying and discrimination, or situations where people do not feel they have a sense of control over their work, can further undermine the mental health of workers (Benach, Muntaner, & Santana, 2007; Bentley, Kavanagh, Krnjacki, & LaMontagne, 2015; Eklund, 2007; LaMontagne et al., 2014; Nieuwenhuijsen et al., 2015). Casualization of work within precarious labour markets or in contexts of economic recession has also been described as an important contributor to poor mental health in otherwise well individuals, as well as more vulnerable population groups (Canivet et al., 2016; Frasquilho et al., 2015).

Personal recovery

The early conceptualisations of personal recovery were strongly influenced by constructs of empowerment, self-determination and choice, as well as (re)claiming rights to a safe, dignified and personally meaningful life within communities, whilst living with a mental illness (Anthony, 1993; Leamy et al., 2011; Shanks et al., 2013). To formalise a model of recovery, Leamy and colleagues conducted a systematic synthesis of personal recovery published within mental illness research (Bird et al., 2014; Leamy et al., 2011). The subsequent *CHIME Personal Recovery Model* incorporates a number of constructs that are both relevant to the career pathways of people with psychosocial disability as well as helping to understand the impact of employment on an individual's personal recovery (Doroud et al., 2015).

CHIME identifies five key dimensions of recovery: 1) **Connectedness** including concepts of peer support, relationships, support from others and being part of the community; 2) **Hope and optimism** in the future, including a belief in the possibility of recovery, motivation to change, hope-inspiring relationships, and, having dreams and aspirations; 3) **Identity** through (re)building or (re)defining positive senses of identity, and, overcoming stigma; 4) Finding **Meaning** and purpose in the lived experience of mental illness and developing meaningful life and social roles and goals; and 5) **Empowerment** through personal responsibility and having a sense of control over one's life (Bird et al., 2014; Leamy et al., 2011).

The *CHIME* model emphasises the need to recognise and value all individuals as people with hopes, dreams, desires and capabilities, rather than focusing predominantly on health conditions, impairments and barriers (Salzer & Baron, 2016). This highlights the importance of support services (health and employment), as well as the broader community, having the expectation that people with psychosocial disability can recover and work. Positive expectations should therefore inform the ways that services support individuals to lead their own recovery, including enabling them to have choice and control in relation to employment (Salzer & Baron, 2016; Slade et al., 2014).

Recovery-orientated practice and DES

Recovery-oriented practices are based on a person-first approach that recognises the uniqueness of individuals and that people are the experts in their own lives. They aim to instil the belief that recovery outcomes are both personal and possible, supporting individuals to develop and engage with social, recreational, occupational and vocational activities that are meaningful to them. Service providers listen and learn from individuals through the development of respectful and trusting

relationships, and, ensure individuals are well-informed, supported and empowered to use information to make choices about how they engage with services and the supports they receive. Importantly, recovery-orientated practices strive to challenge discrimination and stigma wherever it exists (Australian Health Ministers' Advisory Council, 2013; Davidson & Chan, 2014; Farkas et al., 2005; Mental Health Standing Committee, 2010).

DES sits within the broader welfare system and the majority of participants engage with DES as part of increasingly punitive mutual obligations to remain in receipt of income support. Recovery-orientated practices are not emphasised within the context of DES policy or contractual arrangements (DSS, 2018a). Indeed, it has been argued the punitive welfare-to-work measures that are increasingly seen within Australia's welfare system, not only make it difficult to support key recovery elements such as empowerment and choice and control, but can be harmful for people experiencing long-term unemployment and significant unaddressed barriers to work (Caswell, Larsen, & Sieling-Monas, 2015; Danneris & Caswell, 2019; Devine, Dickinson, Brophy, Kavanagh, & Vaughan, 2019; Nevile, 2012).

DES has been further criticised as not enabling evidence-based practices known to support people with psychosocial disability into work, highlighted by the poorer employment outcomes attained by these participants (DEEWR, 2014; Waghorn et al., 2007). Poorer outcomes have been attributed to the limited collaboration between employment and mental health services, alongside the undersupply of qualified vocational rehabilitation specialists working within the DES sector, with staff often reported as having minimal experience and training in working with people with mental health conditions (Buys et al., 2015; Byrnes & Lawn, 2013; Giuliani, 2015; Parletta & Waghorn, 2016). When interactions between people with psychosocial disability and support services are not positive, processes of recovery can be further undermined (Deegan, 2000; Russinova, Rogers, Ellison, & Lyass, 2011).

There is, however, evidence that DES frontline staff can be supported to develop skills that are more effective at helping people with psychosocial disability achieve work outcomes (Corbière, Brouwers, Lanctôt, & van Weeghel, 2014). Research by King and Waghorn (2018) for example, found more effective DES frontline staff utilise positive working alliances with job seekers; incorporate psychological interventions within employment supports; and, work with employers to address stigma related to employing people with psychosocial disability. These approaches align with recovery-orientated practices and demonstrate the potential of DES to better support recovery and

employment outcomes. Our study aims to build on this evidence by further exploring factors influencing the mental health and well-being and personal recovery of DES participants.

9.2 Methods

This mixed-methods study was embedded within the Improving Disability Employment Study (IDES). Implemented by the University of Melbourne in partnership with disability and employment services peak bodies and nine DES providers located across Australia, IDES aims to gather evidence on factors that influence sustainable employment outcomes for Australians with disabilities. IDES involves a prospective cohort survey of 369 DES participants. Alongside the survey, qualitative data was collected through 56 in-depth interviews with 30 DES participants with psychosocial disability to more deeply explore their lived experience and their engagement with DES and work. Participants of both the IDES survey and qualitative interviews were all 18 years or above with informed consent collected prior to each survey and interview. Ethics approvals were obtained from the University of Melbourne's Human Research Ethics Committee (ID 1545810.1 & 1750133.1).

Quantitative methods

The IDES survey was piloted in February 2018 with 32 DES participants recruited through DES partners. Wave 1 of the survey was implemented between April and December 2018 with 337 survey respondents conveniently recruited through DES partner frontline workers or via an email link sent to DES clients (Dimov et al., Under review). As the majority of items remained the same from the pilot to Wave 1, we have combined pilot and Wave 1 data for the purpose of this paper. Participants completed an online version of the interview or via Computer-assisted Telephone Interview (CATI). The survey took 30-45 minutes to complete and explored functioning, health and well-being, socio-economic conditions, and engagement with employment services and work (Dimov et al., Under review). Survey participants are invited to complete a follow-up survey approximately 12 months after the first (Wave 2). Wave 2 is currently in the field with data collection due to be completed in early 2020.

Quantitative data variables and analysis

Demographic and socio-economic variables included age, gender, education, and ethnicity. Variables on employment, housing, transport and finances were adapted from the Australian Survey of Disability, Aging and Carers (SDAC) (2016), Life Opportunities Survey (McManus & Lord, 2012), and

the Household, Income and Labour Dynamics in Australia survey (HILDA) (Wilkins & Wooden, 2013) with some items also developed by the research team (Dimov et al., Under review). Mental health was measured using the five-item Mental Health Inventory (MHI-5), a subscale of the Short form-36 (SF-36) general health measure. The MHI-5 has been validated as a screening tool to detect symptoms of anxiety, depression, behaviour control, positive affect and general distress in the past 4 weeks (Rumpf et al., 2001). Our analysis used a generated continuous MHI-5 total score (scale 1 to 100), with higher scores representing better mental health.

The seven-item Personal Wellbeing Index (PWI) was included as a validated measure of subjective well-being. The PWI items elicit respondent satisfaction across the domains of standard of living, health, achieving in life, relationships, community connectedness and future security. The PWI total scores corresponding to a continuous scale (1 to 100) were generated based on previously described frameworks (Cummins et al., 2003; Cummins & Lau, 2005). PWI items also correspond to various components across the CHIME recovery framework.

IDES respondents were defined as having a psychosocial disability through self-report (i.e. reported their main disability was psychological) and responses to the Washington Group (WG) Short and Extended Sets of questions. The WG on Disability Statistics designed these Sets to identify people at risk of disability through nationally-based surveys. The Extended Set items included pain, fatigue and affect items (anxiety and depression) with responses measuring frequency and severity of symptoms (Washington Group on Disability Statistics et al., 2010). If a person did not self-report a specific disability they were assigned to the psychosocial disability group if their main reported difficulties across the Extended Set included daily or weekly anxiety or depression with the level reported as *'a lot'* or '*somewhere in between a little and a lot'*, and, their responses to the Short Set of questions indicated no other or less difficulties in other domains (vision, hearing, mobility).

IDES survey data was entered into Stata 15 for analysis (StataCorp, 2017). Descriptive analysis was undertaken to identify demographic and socio-economic characteristics (age, gender, education), and experiences in the labour market (access to paid work, factors impacting on access to work, discrimination) and differences between participants with psychosocial disability and participants with other types of impairments (i.e. participants with physical, sensory, cognitive or multiple impairments who were grouped together for the purpose of this analysis). Adjusting for age, gender and education (dichotomised by completed secondary school or did not complete secondary school), linear regression modelling using the MHI-5 and PWI as outcome variables were used to examine the associations between mental health and well-being and a range of exposure variables (engagement with DES and the labour market, discrimination, housing insecurity) in participants with a

psychosocial disability. Findings helped inform the qualitative analysis and were used to triangulate narratives.

Qualitative methods

Qualitative interview participants were recruited across two cohorts, one prior to and one after the DES program underwent reform in July 2018. Participants were recruited: 1) through the IDES survey, or 2) directly through DES partners. In the first method of recruitment, potential participants recruited through the IDES survey included respondents who: 1) gave consent as part of the survey to be contacted for follow-up interviews, and 2) identified through self-report within the survey as having a psychosocial disability. Eligible potential participants were contacted by the lead author and provided with a Plain Language Statement (PLS) with information about the qualitative interviews. In the second method of recruitment, DES frontline staff working with people with psychosocial disability provided potential participants with information about the qualitative study in the form of a flyer and PLS. DES frontline staff then assisted the lead author to make contact with interested potential participants.

Participants were asked to complete two semi-structured interviews with an interval of six months in between. Thirty baseline and 26 follow-up interviews were conducted with DES participants with psychosocial disability between November 2017 and April 2019. All interviews were conducted by the lead author. In the baseline interview, participants were asked about their life circumstances (family, education), mental health, work (including barriers, supports and aspirations); and, about their experiences with DES. In the second interview, participants were asked about any changes that had occurred in their lives since the first interview, including in relation to their life circumstances, mental health, and employment; supports received from DES provider and/or others; and, choice and control in their engagement with DES. Each interview lasted approximately 45 minutes. Interviews were audio-recorded and later transcribed.

Qualitative narrative analysis

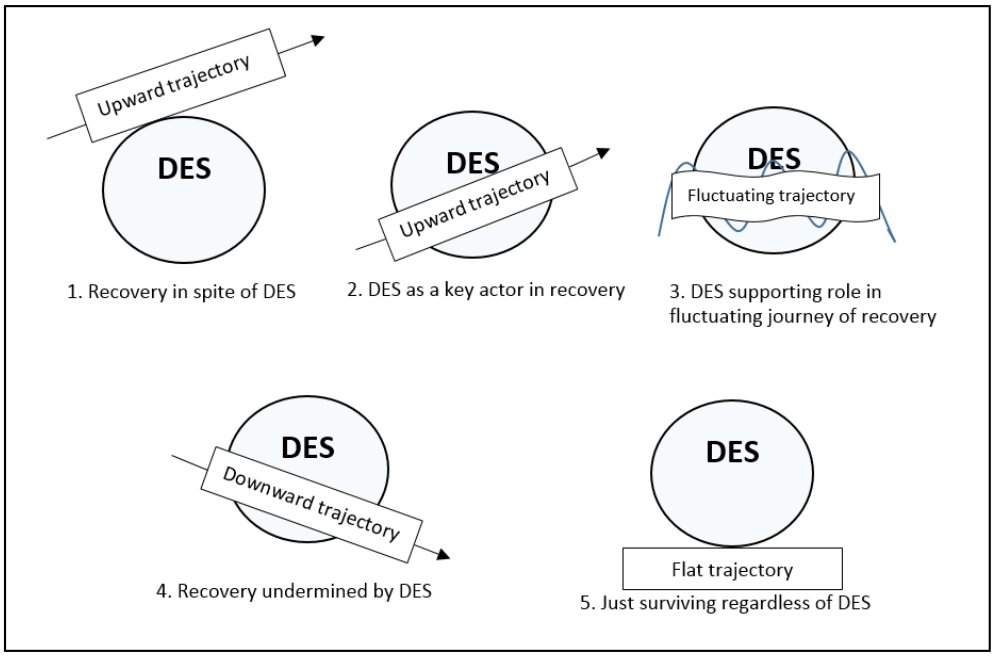
Narrative inquiry has been previously used to explore various lived experiences of phenomena (disability, supported-decision making, unemployment) (Clandinin, 2006; Ezzy, 2000; Gray, 2001; Holland et al., 2006; Knight et al., 2018). Ridgway (2001) for example used first person narratives to explore lived experiences of recovery of women with long-term psychosocial disability, describing how these narratives could inform recovery-orientated practice. Whilst a recent systematic review of mental health recovery reported on 45 separate studies documenting personal recovery

narratives, demonstrating the wide utilisation of narrative inquiry to understand perspectives of recovery (Llewellyn-Beardsley et al., 2019).

Our narrative analysis began with multiple readings of each transcript by the lead author. The initial focus was on identifying life circumstances (childhood, education, socio-economic conditions), experiences (mental health, work, DES), and relationships (family, DES and other services, within employment) given prominence by the interviewee and how these changed over time (Holland et al., 2006). Data were then mapped to the components of the CHIME recovery framework. For example, if participants spoke about support (or lack thereof) with family or services, this data was grouped under Connectedness. Whereas data related to aspirations for work were grouped under Hope and optimism. Emerging themes that did not correlate well with the CHIME framework were grouped separately. For example, expectations of DES providers and whether and how expectations had been met formed a separate category outside of the a priori components of CHIME. Comparisons were then made across the cohort to identify similarities and differences in emerging narrative positions on recovery and how DES was perceived as influencing these positions. For example, noting that recovery can be positioned in narratives as occurring within, despite of, or, outside of systems, some participants clearly talked about improvements in their mental health as occurring outside of the DES system (Llewellyn-Beardsley et al., 2019).

Whereas others clearly positioned improvements in mental health as occurring within DES. People may also follow different non-linear trajectories of recovery and see themselves at different stages of their journey (recovered, living well, making progress or surviving day-to-day) (Llewellyn-Beardsley et al., 2019). This was also evident in the emerging narratives, with some participants reflecting positive trajectories across all CHIME components, with others describing oscillating experiences. Draft findings were shared with the research team on an ongoing basis to ensure the emerging narrative positions were sensical and supported by the broader research and literature. Five main narrative positions were identified with each participant mapped to one of following narratives: *1) Recovery in spite of DES; 2) DES as a key actor in recovery; 3) DES playing a supporting role in fluctuating journeys of recovery; 4) Recovery undermined by DES; and, 5) Just surviving regardless of DES.* See Diagram 9.1 below for a visual representation of the narratives.

Diagram 9.1 Visualisation of narrative positions



9.3 Results

Demographics

The demographic characteristics of IDES respondents are presented in Table 9.1. Just under half of all respondents reported psychosocial disability as their main disability, with just under half of all other respondents reporting psychosocial disability as a co-occurring condition. IDES participants with psychosocial disability were slightly less likely to have a choice in which DES provider they accessed and were more likely to have been engaged with DES for longer when compared with participants with other disabilities. Qualitative participants were more likely to have finished secondary school when compared with IDES respondents, but less likely to have attained post-secondary qualifications. Compared with the current DES population, our sample has a higher proportion of females, and, people with psychosocial disability (48.0% vs 40.7% respectively). There was a similar proportion of compulsory and voluntary participants between IDES respondents and current DES population, with more voluntary participants in the qualitative sample.

The majority of qualitative interview participants reported depression and/or anxiety as the main condition contributing to their disability, with others reporting psychosis and/or Post-Traumatic Stress Disorder. Many participants reported disrupted education, with a third not completing secondary school. Table 9.2 outlines the employment status of interview participants at baseline and

follow-up, demonstrating the most common changes include moving from unemployment to studying, and, moving from part-time to full-time work.

Table 9.1 Baseline demographics

IDES survey respondents					**Qualitative respondents**	**Current DES population**
		Psychosocial n(%)	Combined other n(%)	Total n(%)	n(%)	n(%)
Gender	Female	118 (66.7)	94 (49.0)	212 (57.5)	14 (46.7)	124,416 (46.8)
	Male	58 (32.8)	96 (50.0)	154 (41.7)	15 (50.0)	141,559 (53.2)
	Non-binary	1 (0.6)	2 (1.0)	3 (0.8)	1 (3.3)	NR
Age	18-24	21 (11.9)	24 (12.5)	45 (12.2)	1 (3.3)	39,084 (14.7)
	25-34	52 (29.4)	35 (18.2)	87 (23.6)	13 (43.3)	43,365 (16.3)
	35-49	60 (33.9)	46 (23.9)	106 (28.7)	13 (43.3)	73,490 (27.8)
	50 and over	44 (24.8)	84 (44.7)	126 (35.3)	3 (10.0)	109,736 (41.2)
Reporting other disabilities	Physical	38 (21.5)	15 (7.8)	53 (14.4)	6 (20.0)	NR
	Sensory	11 (6.2)	29 (15.1)	40 (10.8)	-	NR
	Psychosocial	-	88 (45.8)	94 (25.5)	-	NR
Highest level of schooling	< Primary school	2 (1.1)	1 (0.5)	3 (0.8)	-	NR
	Some high school <Y10	18 (10.2)	21 (11.0)	39 (10.6)	4 (13.3)	NR
	Year 10	33 (18.6)	46(24.0)	79 (21.4)	1 (3.3)	NR
	Year 11	27 (15.3)	37(19.3)	64 (17.3)	4 (13.3)	NR
	Year 12	96 (54.2)	86(44.8)	182 (49.3)	21 (70.0)	NR
Post-school qualifications	None	32 (18.1)	48(25.0)	80 (21.7)	16 (53.3)	NR
	Apprenticeship/ trade certificate	27 (15.3)	35(18.2)	62 (16.8)	2 (6.7)	NR
	Other certificate (I-IV)	55 (31.1)	62(32.3)	117 (31.7)	6 (20.0)	NR
	Associate degree/ diploma	27 (15.3)	24(12.5)	51 (13.8)	1 (3.3)	NR
	University degree	35 (19.8)	21(11.0)	56 (15.2)	5 (16.7)	NR
Type of income support/ welfare benefit*	Newstart	131 (74.4)	142 (74.7)	273 (75.6)	19 (63.3)	202,059 (76.0)
	DSP	27 (15.34)	51 (26.6)	78 (21.2)	8 (26.7)	28,271 (10.6)
Engagement in DES	Compulsory	135 (76.3)	145 (76.7)	280 (76.5)	17 (56.7)	206,155 (77.5)
	Voluntary	42 (23.7)	47 (23.3)	89 (23.5)	13 (43.3)	59,820 (22.5)
Choice in provider	Choice	64 (48.9)	74 (51.7)	138 (50.4)	11 (36.7)	NR
	No choice	67 (51.1)	69 (48.3)	136 (49.6)	19 (63.3)	NR
Length of time with current DES provider	12 months of more	86 (53.4)	74 (43.5)	160 (48.8)	7 (23.3)	NR
Employment history	Ever in paid employment	160 (90.4)	173 (90.1)	333 (90.3)	26 (86.7)	NR
	Currently in paid employment	54 (33.7)	43 (24.9)	97 (29.1)	5 (16.7)	NR
Housing	Experienced insecure housing or no place to stay in last six months	25 (14.1)	18 (9.4)	43 (11.7)	8 (26.7)	20,126 (7.6)**
Total		**177 (48.0)**	**192 (52.0)**	**369 (100)**	**30 (100)**	**265,975 (100)**

NR: Not reported by Department of Social Security (DSS). DSS only report primary disability which is described in the text.
***** Welfare support in Australia includes various pensions and income support payments for people who are unemployed. Income support payments generally have mutual obligation requirements attached, i.e. recipients are obliged to actively look for work (compulsory job seeker status). Disability Support Pension sometimes have compulsory requirements

depending on age and assessed level of capacity. Newstart is the main form of income support for Australians of working age who are unemployed. Two qualitative participants were not receiving any income support, while one was on sickness benefits. ** DSS data reports homeless status as opposed to IDES which collected data on experiencing insecure housing or no place to stay in last six months.

Table 9.2 Employment status of qualitative interview participants at baseline and follow-up

Employment status	Baseline	Follow-up
Working full time	0	4
Working part time and requiring more hours	3	-
Working part time and studying	2	2
Studying and looking for work	1	4
Volunteering and looking for work	3	3
Volunteering and studying	1	2
Unemployed, not studying or volunteering	20	8
No longer in labour market or DES*	-	3
Lost to follow up	-	4

*One participant left DES and the labour market after becoming a parent.
Two participants left DES and were not currently looking for work.

Participant expectations of DES workers

IDES respondents were asked a series of yes/no questions about what support they would like from their DES worker. Respondents with psychosocial disability were most likely to report they wanted their DES work to support them to feel confident in their abilities. This was followed by offering suggestions about what sort of work they may be suited to, and, wanting support once they were in a job. (See Table 9.3).

Table 9.3 Supports IDES respondents' would like from DES workers

Supports	Psychosocial n(%)	Combined other n(%)	Total n(%)
Support me to feel confident in my ability	114 (64.4)	109 (56.8)	223 (60.4)
Provide me with support when I have a job	104 (58.8)	125 (65.1)	229 (62.1)
Offer suggestions about what sort of work I might be good for	102 (57.6)	112 (58.3)	214 (58.0)
Help me apply for a job	96 (54.2)	103 (53.6)	199 (53.9)
Help me find a training course	89 (50.3)	86 (44.8)	175 (47.4)
Help me prepare for a job interview	84 (47.5)	86 (44.8)	170 (46.1)
Assist me with Centrelink	73 (41.2)	95 (49.5)	168 (45.5)
Help me participate in decision-making	59 (33.3)	67 (34.9)	126 (34.2)

Mental health and well-being

As demonstrated in Table 9.4, IDES participants with psychosocial disability had on average significantly lower MHI-5 and PWI scores (means, 44.9 and 48.4, respectively) compared to participants with other disabilities (means, 55.8, 54.3). The PWI total scores for participants with psychosocial disability are below the normative score of 50 within the Australian population (Cummins & Lau, 2005). In terms of the PWI individual domains, participants with psychosocial disability report significantly lower levels of satisfaction across all domains compared with participants with other disabilities, with the exception of satisfaction with health.

Table 9.4 Comparison of mental health (MHI-5) and well-being (PWI) between individuals with psychosocial disability versus any other disability type combined. The seven PWI domain scores (scale between 0 - 10 or no satisfaction - complete satisfaction, respectively) are also presented. P-values are from linear regressions of disability type (psychosocial, other combined) on outcome variables (MHI-5 and PWI).

Outcome variables		Psychosocial mean (± 95% CI)	Combined other mean (± 95% CI)	p-value
MHI-5 total		44.9 (41.7, 48.2)	55.8 (52.2, 59.5)	<0.01
PWI total		48.4 (45.3, 51.5)	54.3 (51.0, 57.5)	<0.01
PWI individual domains – satisfaction with:	Standard of living	5.5 (5.1, 5.9)	6.0 (5.6, 6.4)	0.07
	Health	4.8 (4.4, 5.1)	4.4 (4.0, 4.8)	0.20
	Achieving in life	3.9 (3.5, 4.3)	4.7 (4.3, 5.1)	0.01
	Personal relationships	5.5 (5.2, 5.9)	6.1 (5.6, 6.5)	<0.01
	How safe you feel	6.3 (5.8, 6.7)	7.0, (6.6, 7.4)	<0.01
	Feeling part of community	4.6 (4.1, 5.0)	5.2 (4.8, 5.6)	0.04
	Future security	3.9 (3.5, 4.3)	4.7 (4.2, 5.1)	0.01

Linear regression analyses of survey respondents with psychosocial disability, adjusting for age, gender and education, found that while compulsory engagement with DES was not associated with significantly lower PWI or MHI-5 scores when compared to voluntary participants, participants with psychosocial disability who reported having no choice in which DES provider they accessed, had significantly lower PWI and MHI-5 scores. We did not find evidence to show that length of time in DES was associated with changes in PWI or MHI-5 scores (See Table 9.5). Participants who were currently employed had higher PWI and MHI-5 scores compared with participants not currently in paid employment. Of participants with psychosocial disability who had ever worked, those currently working fewer or more hours than they would like had lower PWI and MHI-5 scores when compared to participants working about the number of hours per week that they would like. Individuals on permanent/fixed term contracts, also had significantly higher PWI and MHI-5 compared with individuals on casual contracts. In relation to choice in their careers, survey participants who felt

they had only some or no choice in their career options, had lower PWI and MHI-5 scores when compared to participants who felt they had complete choice over their career choices. Those reporting disability-related discrimination and housing insecurity were also more likely to have lower PWI and MHI-5 scores (See Table 9.5).

Table 9.5 Factors affecting well-being and mental health for IDES respondents with psychosocial disability. P-values are from linear regressions of each exposure on PWI and MHI-5 outcomes and are adjusted for age, sex and education.

Exposure variables		PWI total mean (± 95% CI)	p-value	MHI-5 mean (± 95% CI)	p-value
Completed secondary school	No	45.9 (38.6, 53.3)	-	41.5 (33.8, 49.2)	-
	Yes	50.8 (37.0, 64.6)	0.14	44.0 (29.6, 58.5)	0.45
Compulsory engagement in DES	Yes	45.5 (38.1, 53.0)	-	40.9 (33.0 48.5)	-
	No	48.2 (33.1, 63.3)	0.49	45.6 (29.5, 61.5)	0.25
Choice in provider	Yes	52.4 (43.5, 61.2)	-	48.2 (38.8, 57.5)	-
	No	39.5 (23.8, 55.3)	<0.01	36.1 (19.6, 52.5)	<0.01
Length of time in DES	<3 months	47.2 (36.1, 59.3)	-	42.5 (31.6 53.4)	-
	3-6 months	45.2 (21.4, 69.0)	0.76	38.0 (14.3, 61.7)	0.48
	6-12 months	46.3 (22.9, 69.8)	0.90	41.4 (20.8, 64.3)	0.85
	>12 months	46.1 (25.8, 66.6)	0.84	40.8 (20.8, 60.8)	0.71
Experience disability-related discrimination	Yes	40.0 (32.7, 47.2)	-	34.7 (27.1 42.3)	-
	No	56.1 (42.8, 69.4)	<0.01	51.2 (37.3, 65.0)	<0.01
Ever employed	Yes	46.2 (38.6, 53.7)	-	41.4 (33.6, 49.2)	-
	No	44.8 (26.3, 63.3)	0.80	42.3 (22.9, 61.6)	0.90
Currently employed	Yes	53.2 (43.9, 62.5)	-	50.5 (40.8, 60.2)	-
	No	43.4 (27.0, 59.9)	0.01	39.9 (22.7, 57.2)	<0.01
Preference to work	Fewer hours	41.8 (20.9, 62.7)	-	30.9 (10.7, 51.0)	-
	About the same	60.3 (20.5, 99.0)	0.05	56.3 (17.7, 94.9)	<0.01
	More hours	53.7 (14.9, 91.7)	0.19	43.0 (5.2, 80.7)	0.13
Employment arrangement	Permanent or ongoing	65.8 (52.4, 79.0)	-	58.8 (44.6, 73.0)	-
	Casual or temporary	53.7 (29.0, 78.5)	0.04	43.7 (17.2, 70.3)	0.02
Choice in career/job	No choice	30.6 (21.0, 40.3)	-	34.1 (23.5, 44.7)	-
	Some choice	43.9 (26.0, 61.7)	<0.01	40.5 (21.1, 29.4)	0.15
	Complete choice	54.3 (35.7, 72.8)	<0.01	45.4 (25.1, 65.8)	0.02
Experienced no place to live/stay in last 6 months	Yes	38.5 (28.2, 48.8)	-	30.1 (19.2, 40.9)	-
	No	47.9 (28.7, 67.1)	0.03	43.9 (23.7, 64.1)	<0.01

IDES respondents reporting choice in DES provider, were asked about the importance of various factors in informing this choice. Response options were scaled 'Not important', 'Somewhat important', and 'Extremely important' with Table 9.6 presenting the latter. Of most importance to all respondents was that the DES provider would recognise their strengths. This was followed by choosing a DES provider that was easy to get to, and, a provider that makes individuals welcome and has experience with their type of disability.

Table 9.6 Considerations when choosing a DES provider

	Psychosocial n(%)	Combined other n(%)	Total n(%)
Recognise my strengths	45 (72.6)	55 (76.4)	100 (74.6)
Easy to get to	49 (62.8)	51 (58.0)	100 (66.2)
Make me feel welcome	49 (62.8)	55 (62.5)	104 (62.7)
Experience with my disability	48 (61.5)	54 (61.4)	102 (61.5)
I will have the same consultant every time	45 (57.7)	52 (59.1)	97 (58.4)
Good reputation	47 (47.4)	37 (42.1)	74 (44.6)
Can use the internet	14 (18.0)	14 (15.9)	28 (16.9)

Note: Not all respondents responded to each item in the series.

9.3.2 Narratives of recovery

Similar to IDES survey respondents, interview participants' often experienced poor mental health and well-being in and of itself, and, in relation to factors such as unemployment and/or the sense of control they felt in relation to their employment, insecure housing, and discrimination. Analysis of qualitative interview data enabled a more in-depth analysis of these factors, alongside exploration of the working relationship between DES workers and participants, leading to the formation of the five narratives.

1) Recovery in spite of DES

About one fifth of participants strongly resonated with a positive journey of recovery, attained in spite of their engagement with DES. Living with and learning from their experiences with mental health defined these journeys of recovery: 'I feel like it has happened to me for a reason.' (Participant#16 follow-up, P16b). Mental illness for these participants was often precipitated by trauma (military service, abuse from multiple perpetrators), with recovery facilitated by a combination of intrinsic traits (motivation, determination); support from others (family, peers); and, services (mental health, justice, rehabilitation).

> *Two police officers saved my life … I was homeless at the time … I wanted to jump in front of a train. Not because I was depressed but because I completely wanted to go to heaven … They put their arm around me and they said they wanted to get an ambulance 'Will you do that for us?' … If they hadn't stopped me that day I would be dead.* (P8 baseline, P8a)

Along their journey's, participants had been receptive to supports and non-DES services they felt had been congruent with their needs and available at the right time: 'You have to actually want help and be willing to utilise a service that you are getting to make it work probably.' (P28b), yet acknowledged help is not always available: 'It actually takes someone to hit rock bottom or even go to jail. It's just so sad that it gets to that point.' (P16b). Entwined in these concerns, was a pressure to stay well due to the limited availability of mental health services. There was also a strong desire to help others with mental illness and advocate for change and better systems of support.

> *That is one thing that keeps me inspired to stay on top of things … I know how bad it can get. It would be good if we could try and get this stigma aside and help people get well. Because they are even closing down places, like mental health places.* (P8a)

> *I want to live my optimum life and my optimum life is not about the outward things. It is about the optimal inside. I was not mad. People had corrupted my life … I am taking positive action to try and stop it … I am a real advocate. I am fighting for change.* (P24a)

Clearly articulated aspirations relating to work and the value of work were also central to these recovery journeys: 'I want to be a community social worker, to help make the community better for him [newborn baby]. My main reason now, my main focus is to make everything better for my son.' (P28b). For some, recovery was directly linked to attaining work within an organisational setting congruent with their skills, ways of working and values: 'The culture is familiar and because the attitudes and the behaviours of the staff are similar to what I've had before, it is not like I'm having to completely reinvent myself to add value … this helped me be able to apply knowledge and skills and contribute. … So from that point of view there is less stress.' (P4b). Others were not yet in careers they aspired to, but recognised their progression towards their ideal careers through paid work in other fields, volunteering or study: 'I probably spent about two or three years recovering and now I'm back at Uni. Because I have got everything under control I've been able to get good grades …It can be stressful at times, but even with the volunteering, I come back home and I feel a lot better.' (P14a).

Similar to the positioning of recovery occurring in spite of DES, attaining work and its role in supporting recovery, was defiantly spoken of as being achieved external to DES: 'I did get this job on my own. It wasn't like I had actually received a direct benefit from enrolling in the service.' (P4b). Particularly during follow-up interviews, DES was often described as frustrating the process of finding work. People often felt their time was wasted by DES frontline workers who seemed unable to connect them with information, pathways or employers relevant to their job aspirations. Some

people described being sent to inappropriate job interviews that left them feeling dejected, whilst others felt DES were not effectively responding to their complex employment barriers.

> *Especially for someone that has got the disadvantage of a criminal record, and apparently they specialise in that? It's such a long process and when you are wanting to work, it should be like 'okay you want work, great' and get you in the rhythm of getting into work rather than sitting in a funk … That's a real struggle and that's what I found … I got my own job so it's too late now.* (P16b)

Not only was DES a hindrance for these participants in relation to finding work, they reflected DES should be more effective in supporting the recovery of people with mental health conditions: 'Employment services need some counselling skills. They don't have to be counsellors but they can help develop new ways for people to think.' (P24a). Indeed, some participants who were not in work, felt their recovery was somewhat vulnerable within DES. 'I'm proud of how far I've come. I'm just ready to work. I don't want to not be in work for so long that I might start to go downhill internally. Because I might start to lose hope. So it may be like [DES provider] need to push a bit more.' (P8b)

2) DES as a key actor in recovery

> *My journey has been so hard for so long … I may have moments where I wish I had ended it, but at the end of the day I have a family that loves me … Years ago I wouldn't have said that I want to get out there and be a productive member of society… It has been the support from my dad and mum and its helped big time. And it's also thanks to* [DES worker] *because he has given me enough support.* (P30a)

Similar to narrative one, these participants took pride in their journeys of recovery but were more likely to acknowledge external support mechanisms facilitated their recovery. This was evident for approximately one quarter of participants. Finding meaning in their experiences similarly transpired into a desire to help peers: 'I am really passionate about mental health … like getting people to connect … The majority of people who commit suicide, there is a lot of them that have been out of work for years. So I just feel that if people didn't feel so alone and met other people in similar [circumstances] it might help'. (P12b). Hope and work-related aspirations were also present: 'I want something more productive. I feel like before all I used to do was go to drop-ins and sit around and

have coffee all day. I went to these groups for about 22 years. I feel I want something different now … I want volunteering or paid work.' (P2b)

The main difference between this narrative and the first is the positioning of DES as a key component of their recovery: '[DES worker] has been like really helpful. Like all the way through. Like constantly checking up on me and he has been really engaged' (P30b). Positive relationships with their DES worker were often described as a change for the better when compared to previous workers, and, emphasised as being proactive and effective: 'The other job places … you signed in, stamp your name, leave. It seems they don't really care about you. But here they actually talk to you and sit down and make plans with you and try to actually help … For the first time in a while I'm feeling good about getting a job.' (P22a). Evidence of engaging with employers and job matching also featured more frequently in these narratives: 'They said that they knew this place that was available, like looking for baristas. They put my name through and they gave me a call and wanted me to come in for a trial and yes, she was really happy.' (P27b). Workers that were more readily able to identify and at least attempt to address multifaceted barriers to work were recognised as critical to employment outcomes and also demonstrated to participants that they were valued as a person.

> [DES worker] *has been really concerned about getting me some kind of further help … just looking into different things that can help me or make me feel better physically and mentally … I think they are doing as best as they can until we come up with an idea and we try something or something falls into place.* (P19b)

There were, however, tensions in these stories. Some had been helped into full-time work - albeit not in something meeting their aspirations or desire for part-time work. This left people in a fragile position of being more stressed and too busy to access their mental health supports. They also found it difficult to access ongoing DES support to help with workplaces challenges and career development.

> [DES worker] *said to stay in touch, but I can't get to them because I work when they're open. Which is a pain because I love sitting down with* [DES worker] *and talking about everything. The other day I had a phone interview* [with DES worker] *but they never called and I was devastated because I could probably do with it … as much as I love this job I am always wondering what courses or things that I can do as well … and just to be able to debrief about little things that are upsetting me and get their advice … That is where I'm at with that and I try to cope. Keep strong … ride it out … I am not seeing the psychologist, because I don't know where to fit this into my life anymore.* (P6b)

Similar to narrative one, some participants felt DES could be more effective if they were better integrated with mental health supports: 'I think if there was a GP here or a nurse or a psychologist or social worker or something so when people are like that and they come in like that [experiencing significant mental health distress], they can talk to someone or a counsellor and I do know I think it would help.' (P12a).

3) DES playing a supporting role in fluctuating journeys of recovery

This narrative was symbolised by fluctuating journeys of recovery punctuated by events and circumstances (family breakdown, homelessness, unemployment) that challenged participants' mental health and sense of control over their lives: 'It's [suicide] tempting when you are in the depths of the darkness. But you always have to have some sort of hope and that is what the support group has got and the priest … very tiny steps that's the way it is … whether I make it to the finish line in the end is another story.' (P15a). The four participants within this narrative were typically tethered to their journeys by a sense of responsibility. This included caring for siblings due to parental mental illness or commitment to serve their community.

These participants were less socially connected compared with people in previous narratives: 'I think probably years of being isolated most of the time … not necessarily written off but it is hard to find a group.' (P20a). DES was therefore seen as a mechanism for social inclusion: 'I was required to come in on a Monday but I used to come every couple of days to do the [online] course. It's a nice place compared to the public library.' (P20b). Work was also seen as important for improving their connections with others, with narrators unified by the positive belief that work was possible despite significant vocational and non-vocational barriers. DES was positioned as central to helping them achieve this, even if it was a long-term goal.

> *It's part of my process of trying to get my feet on the ground again. I want to serve, but I cannot compete on the same level as someone searching on* [job-seeking platform] *because of lack of experience. I have been out of the workforce for quite a while, plus maybe my mental illness may hinder this process. However, I thought to myself there must be an agency that caters for people like me … I gave a call to* [DES worker] *and she said come in.* (P15a)

Similar to the second narrative, positive relationships with their DES worker across the two interviews, was fundamental to helping them feel more empowered in relation to work: 'He said to me "First up I'm not gonna get you a job, but I got the tools to help you get a job" … I did a mock interview last time when I was in this room. It wasn't that great but when I did it again he said it was 1000 times better.' (P23b). At the time of follow-up, all had been supported by their DES worker to engage with vocational training. DES workers were described as helping to identify courses aligning with their aspirations, covering costs, or encouraging participants when studying was challenging.

> *There is actually some direction now. Even recently with* [DES provider] *I was like well I don't really know what to do. So with everything I was reluctant. … Eventually we settled on something. Now everything is going forward and I am studying …* [Previous DES provider] *would be putting me in for jobs without asking me and it was just horrible. But here, it is like* [DES worker] *actually listens to me and he doesn't do things without me, without making sure I'm okay with that.* (P29b)

Concerns were, however, raised during the second interview that services were changing, threatening the positive positioning of DES and creating anxiety. Internal training offered by DES for their clients, which also provided much valued peer support for example was less likely to be offered. There was also uncertainty regarding the stability of DES, precipitated by a higher than usual turnover of staff: 'I'm just afraid that they might be leaving soon … they are changing people all the time … Are they going to close down? Because if they got a new provider, then somewhere down the line that place might go bust too.' (P23b).

4) Recovery undermined by DES

Participants whose accounts aligned with this narrative were again proud of what they had overcome, accepting of their mental health, and, identified career paths where their experiences could help others. The four participants within this narrative were voluntary participants in DES and had strong aspirations to work.

> *I won my life back. … I can look back and reflect and instead of regretting everything, I can say oh well I have learnt now. I can do my own research. Be my own boss. Don't wait for people to do things for me … If I did a Diploma in Community Services I think I could get a job working with homeless people. I have firsthand experience and I think that would help … I just remember how hard that was … I was pregnant and scared … I do think it makes you a lot stronger when you come out of that*. (P25a)

Yet for these people, DES was distinctly positioned as undermining recovery with their initial optimism deteriorating over time. Whilst all experienced significant challenges in their lives (including housing, and, trauma related to previous violence), their engagement in DES and its impact on their mental health, recovery and employment outcomes dominated their stories: 'I am really frustrated. At first my worker was like "Yes this is my role, you have a disability you have a right to a reference so that you can get work again." I think she rang them once or twice … and then she gave up, which is like writing off my career.' (P1b).

Interviews highlighted these participants' negative relationships with their DES workers whereby participants felt they were not listened to, and their skills and aspirations disregarded: 'People need to listen to what they want and not just bulldoze over them. Which I feel that [DES provider] has been doing, like just bulldozing over me. Like telling me not to go for animal welfare jobs because there aren't enough jobs out there. And when I go for [animal welfare] jobs, I see plenty.' (P3b). DES workers also tended to allocate people into jobs that threatened their mental health. For some this pattern became intolerable and at the time of follow-up they had left DES and the labour market.

> *I just found I kept going to* [DES provider] *but the girl was suggesting things, that I understood she didn't understand me and my illness. She would suggest to me to go and do traffic control on the road … my anxiety would be through the roof … they were not actually listening to me and thinking 'let's find a part-time job that will really suit her and that she can actually do' … I just felt like it wasn't going anywhere and it was wasting my time going there so I didn't bother … I kept thinking I'm getting a bit unwell, I can't do this anymore.* (P17b)

Concern was further raised that staff were not providing participants with supports they knew (or found out later) were available. This was incredibly distressing for participants as they already had so much to overcome when trying to find work. This knowledge, compounded by life circumstances, again led to people dropping out of DES. Through these examples, participants described approaches that they felt would benefit recovery as well as efforts to find work.

> *I also found out there was ways they could have helped me after the situation had occurred … I was going to the pool to get ready* [for an interview] *… I was telling them about it, and she was saying 'We have got a place here with a shower.' … I was informed of that two weeks before I left the service. … I didn't have anything to wear for an interview … then I was*

told I could have had a voucher for clothing. That was really disappointing. I am sure they want to minimise the amount of resources they give to each client, but that would give them [participants] *a better service … Looking for a job is quite a gruelling situation … It's scary for a normal person let alone someone with mental health problems. Like those feelings of rejection are more intensified. I would have liked to have had an opportunity to debrief with them after each interview and maybe time with them before.* (P1b)

5) Just surviving regardless of DES

Narrative five was the most common with nearly a third of all participants mapped to this narrative. Their journeys were epitomised by a persistent, often exhausting battle of survival: 'When you fight for so long you just get tired of it. So you don't give up, you just give in.' (P10b). Circumstances remained stagnant or deteriorated over time with few (if any) elements of recovery described. Mental health was a challenge in and of itself, but was often made more difficult by isolation, poor physical health and ongoing trauma: 'I'm pretty sure many of the people they call me treatment resistant… I am still in the same overall situation. Being socially isolated is probably my biggest problem.' (P21b).

Issues with DES and the labour market were woven into challenges encountered within broader systems (welfare, justice, education, health). Participants described themselves as slipping through systems: 'I just slipped out of the [education] system somehow. It seems to be something I do very well.' (P10a); finding systems difficult to negotiate: 'I applied for the [disability] pension but I didn't know how to go about it' (P18a); or, having a sense of being under siege: 'If I am to put my child first as I am, work is a secondary thing. And that is the whole point. The family law and the family violence process is designed to break people. … I will never have capacity to work again.' (P9a). Participants also found it difficult to recognise their skills and how these could be harnessed to transition back into work: 'I get overwhelmed, it's especially even harder now, going through career change … when you're feeling low you don't feel like you have any [skills].' (P26a)

Extensive periods of unemployment despite long-term engagement with DES were common. The few participants in this narrative that wanted to work felt let down by DES, often describing their DES workers as ineffectual and not understanding of their mental health, which made looking for work more challenging. Relationships with these workers had a negative impact on already precarious mental health as well as work aspirations. This was particularly so if they had a positive experience with a previous worker: 'Before that I saw [previous worker] and he is fabulous … now I

just feel like I'm coming in to hand in my list … It has really made me shut down over the last six months … now I feel stressed coming here.' (P7b)

Others were engaged with DES more because of their welfare mutual obligations rather than thinking it would lead to employment outcomes. Relationships with DES and work in these instances differed across interviewees. For some, whilst the relationship with their DES worker remained positive, their mental health made it difficult to engage with DES and the labour market challenging: 'I need to work but the mental health does take priority, it kind of strips it away. [DES] are doing a good job … there are still days when everything is just blank that is the best way to describe it. Half the time my world is empty, because it is easier being empty than full.' (P10a). For others, the relationship with DES seemed mired in power imbalances, which subsequently seem to compound stigma related to unemployment: 'There is pressure and guilt tripping involved … [DES worker] says "you know if you're five minutes late we will dock your pay" [income support payment]. I think most people just turn up and keep quiet and make the right noises.' (P21b).

9.4 Discussion

Nearly half of the IDES survey respondents identified psychosocial disability as their primary condition, with just under half of all other respondents identifying co-occurring psychosocial difficulties (DSS, 2020). These findings demonstrate a significant number of participants could benefit from recovery-oriented practices within DES. Our qualitative findings further highlight the positive influence on recovery that is possible when DES workers adopt approaches that align with recovery-orientated practice. Such approaches however were not consistently reported across the sample. Each narrative, alongside the quantitative findings, also reveal participants' perspectives on how DES and the systems that surround it, could improve support towards the recovery and employment outcomes of people with psychosocial disability.

Consistent with government data highlighting Australians with disabilities experience poorer employment outcomes when compared to Australians without disability (ABS, 2016), just under a third of the IDES cohort reported they were currently employed. This is despite the majority of respondents being engaged with DES for at least 12 months. Respondents also reported a high prevalence of factors known to undermine access to work, including disability-related discrimination and insecure housing.

Re-iterating the important role work can play in recovery, quantitative respondents with psychosocial disability who were currently working, had significantly higher mental health and well-

being scores compared to those not in paid employment. However it is possible that those with better mental health to begin with were more likely to be employed (Slade & Longden, 2015). The positive relationship between work and mental health recovery was similarly observed in the qualitative findings. This is particularly so when participants found secure work that was congruent with their skills and aspirations, in organisations that aligned with their personal values and ways of working values, as seen in narrative one (Szymanski et al., 2012).

Individuals in narrative one were the most likely to be working, most strongly identified with all five elements of CHIME, and, were most strongly connected to the labour market. Their intrinsic motivation to work was often frustrated by the perceived ineffectiveness of DES. Indeed, those who were working reported employment was found independently of DES. Whilst DES was not positioned as supporting these journeys, these participants had been receptive to help provided through other non-DES services and supports. Participants highlighted the need for more investment in mental health services so people can receive support before they hit rock bottom. This was expressed alongside concern at the perceived decrease in availability of mental health services in Australia. Echoing previous research, concern was also raised regarding the limitations of DES frontline workers to adequately support participants, highlighting a need to develop basic skills in counselling and motivational interviewing (McDowell, 2018).

Quantitative findings highlight that many respondents want DES providers to recognise their strengths and support them to feel more confident in their abilities to work. Qualitative participants aligning with narrative two and three seemed more receptive to the support they felt was provided to them within their engagement with DES. As highlighted in these narratives and other research, perhaps a greater individual need for support was matched with more highly-skilled workers that could work within DES to develop more positive worker-participant alliances (Denhov & Topor, 2012; J. King & Waghorn, 2018; McDonald & Marston, 2006; Nguyen & Velayutham, 2018). Such DES workers were described in ways that most resonated with recovery-orientated practice, in that they were reported to take the time to develop trusting relationships, and listen and respect the hopes and aspirations as well as the fears and concerns of participants. Whilst only a small number had been supported into work, the majority of participants within these narratives had been supported into further education and training. As observed in other studies, positive vocational steps towards work in turn helped these individuals on their journeys of recovery (Doroud et al., 2015).

The importance of matching individuals with a DES worker that suits them is also evident in our findings. Individual DES workers were often reported to very effectively support the career aspirations and decision-making for some individuals and do so very ineffectively for others. DES

participants are diverse, and building the capacity of DES workers to respond to diverse needs using recovery-orientated approaches would benefit more people. Recovery-orientated approaches may similarly be encouraged by enabling participant choice in which DES worker they are attached to and to change if they feel positive support is not being achieved. Correspondingly and aligning with research by Simonsen et al (2013), IDES respondents who felt they had complete choice in decisions relating to their careers and choice in DES provider, had higher mental health and well-being scores, when compared to those with only some or no choice.

As highlighted in this research and in the work of Milner et al (2019) and Butterworth (2013), when the psychosocial needs of workers are undermined in work, the mental health and recovery of individuals is threatened. Providing post-placement support to individuals to help them manage psychosocial stresses in the workplace is thus vital. This was underscored by quantitative findings demonstrating the importance to participants of DES support when they do find work. Similarly, interview participants placed in full-time employment despite a desire for part-time work, found it hard to access their mental health supports. In these circumstances, ongoing employment support that is meant to be provided within DES was not being effectively implemented, placing some individuals in vulnerable positions in terms of their mental health and undermining their longer term career development (Simonsen et al., 2013).

This is supported by our quantitative findings, which highlight that IDES respondents with psychosocial disability who reported working 'about the same hours' as they would like had significantly higher mental-health and well-being scores when compared to people working more or fewer hours than they would like. Similarly, people in our sample with more secure working arrangements (permanent/fixed term) were also found to report higher mental health and well-being than those who were casually employed. This resonates with research by Morgan et al (2012) and Fasquilho et al (2015) that highlight the challenge of finding secure employment in an era of casualization and precarious global economic conditions, and, the negative impact this may have on mental health (2016; Frasquilho et al., 2015; Morgan et al., 2012).

In stark contrast to the first three narratives, the experiences of individuals aligned with narrative four, highlight the negative impact on recovery and employment outcomes when positive working alliances are not achieved and when individuals do not feel listened to, with their hopes and aspirations disregarded. Our findings further align with research that finds mental health and employment outcomes are undermined when DES participants are pressured into jobs or training that don't align with their skills or mental health needs, or, when participants perceive both inequities and ineffectiveness in the services they receive (AFDO, 2014; Nevile & Lohmann, 2011).

Across the qualitative cohort, participants also described the stress associated with the high turn-over of staff occurring within DES, particularly since the 2018 DES reforms. Staff turn-over disrupts relational continuity and forces participants to re-tell their story and re-start the process of building trusting relationships with their workers (Danneris & Caswell, 2019; Devine et al., 2019). This process can take time and be re-traumatising for participants with psychosocial disability who often have difficulty with trust due to past experiences of harm or distress, including sexual assault or coercive interventions (Sweeney et al., 2018). It also highlights the precarious environment DES providers operate within, the pressures on remaining DES staff and how this may impact on their capability to implement recovery-orientated approaches.

More than any other, narrative five underscores a need for greater investment in mental health supports for individuals experiencing significant psychosocial disability within and external to DES. These individuals were least likely to identify with any CHIME components of recovery and would clearly benefit from enhanced access to recovery-orientated employment and community mental health services. This is alongside support to access key social determinants of mental health such as housing, which was a significant issue impacting on mental health and access to work for people across both the qualitative and quantitative cohorts. Yet as is so often emphasised by DES and mental health researchers, Australia must do much more to address systems level challenges to better integrate employment services with other mental health, rehabilitation and social services such as housing (Harvey et al., 2016; R. King et al., 2006; Parletta & Waghorn, 2016; Waghorn et al., 2007).

9.6 Methodological considerations

To our knowledge, this study represents the first survey of DES participants that incorporates existing validated surveys as well as supplementary items to comprehensively examine participant perspectives on factors that support and undermine access to sustainable and meaningful employment. However, the survey was implemented during a time when the DES sector was undergoing considerable reform which hindered recruitment. Because of the relatively small sample some of the estimates have wide confidence intervals due to insufficient power particularly when analyses were restricted to IDES respondents with psychosocial disability. Furthermore, items within the linear regression presented in Table 9.5, did not apply to all respondents with psychosocial disability, decreasing the response rate for particular exposure variables and restricting capacity to run multiple variable analysis. There is no available database for the DES population that can be used

to recruit participants so participants were recruited through a relatively small number of DES partner services and email lists, meaning the sample may not be representative of DES participants. For example, our sample had a higher proportion of participants with psychosocial disability than reported in the DES population. However, there were sufficient numbers of participants grouped under psychosocial disability and the combined other types of disability group to allow for comparisons between these groups where relevant. Our sample did however have far fewer older participants compared with the broader DES population. Older Australians, with and without disability, are known to experience additional barriers to work on account of age-related discrimination (AHRC, 2016). Our findings may therefore not be representative of the disadvantage experienced by older DES participants. The survey was also only offered in English which is likely to have excluded people experiencing the intersectional effects of belonging to a Cultural and Language Diverse community and having a disability (DSS, 2019b; Federation of Ethnic Communities' Councils of Australia & Inc, 2015).

Nonetheless, these findings represent an important contribution to the evidence on the relationship between employment and personal recovery and highlights critical factors for both future research and DES policy makers and providers to consider. Compared to the general DES population qualitative participants were more likely to be in receipt of the DSP and therefore have fewer mutual obligations to engage with DES. Similarly, our qualitative sample were more likely to be voluntarily engaged with DES when compared to the general DES population. These factors may indicate they have been assessed has having more significant disabilities (compared with the broader DES population) that impact on ability to work. They were also recruited through a relatively small number of DES providers and in essence self-selected into the study. Their experiences may therefore also not be representative of the broader DES population with psychosocial disability, or, have been exposed to other models of DES service delivery. The data clearly indicated five distinct narratives to which each qualitative participant could be mapped. However, we cannot rule out that a larger sample size may have identified further narrative positions, even though this is unlikely considering the clear alignment of all qualitative participants to one narrative position.

9.7 Conclusions

Recovery-oriented approaches ensure services are delivered in a way that supports the personal mental health recovery of service users. Alongside access to secure and meaningful work, recovery was facilitated within the context of DES when frontline workers drew on these approaches to engage with participants. These approaches, however, were not consistently applied. Given the

number of people with psychosocial disability moving through DES and the important role that work plays in supporting recovery, encouraging greater consideration of recovery-oriented practice within DES policy and programming and investment in building the capacity of frontline staff is warranted. Such efforts would be more effective however if systems-level barriers were simultaneously addressed. This includes an urgent need to improve access to recovery-orientated mental health services for people experiencing mental illness, together with greater integration and coordination between mental health and employment services to better support DES participants with psychosocial disability on their mental health recovery and employment journeys.

Ethics approval and consent to participate

Ethics approval to conduct this research were obtained from the University of Melbourne's Human Research Ethics Committee (ID 1545810.1 & 1750133.1). Participants of both the IDES survey and qualitative interviews were all 18 years or above with informed consent collected prior to each survey and interview

Acknowledgements

The authors would like to acknowledge all participants, project partners, and researchers who have made this project possible. We would particularly like to acknowledge IDES co-investigator Associate Professor Allison Milner, who passed away on 12 August 2019.

Chapter Ten: Discussion

The aim of this PhD study was to explore the relationships between the life circumstances of DES participants with psychosocial disability and their engagement with the federal government funded DES program. The PhD was embedded within the Improving Disability Employment Study (IDES), which was funded through an Australian Research Council Linkage Project grant. The study was theoretically guided by Szymanski and Hershenson's *Ecological Model for Vocational Behaviour and Intervention for People with Disabilities,* and, the *CHIME Personal Recovery Model*. Drawing on mixed methods interpretivism, quantitative data from Wave 1 of the IDES survey with 369 DES participants was analysed alongside the data from 56 qualitative interviews with 30 DES participants with psychosocial disability. Interview participants were recruited in two cohorts. The first cohort were interviewed prior to when the most recent reforms of the DES program were operationalised on 1 July 2018. The second cohort were recruited and interviewed subsequent to these reforms. This is a thesis with publications. As such, this chapter integrates some key findings that were not included in the papers, yet are relevant to contextualising the thesis in the discussion below. The chapter goes on to discuss policy and practice implications relevant to the DES program. This is followed by a reflection on the strengths and limitations of the study, future research opportunities, and, final conclusions.

10.1 Josephine's story

Participants in this study expressed a strong desire to work, and, perceived that work would improve their socio-economic conditions and mental health recovery. Consistent with the existing literature, participants who were working experienced better mental health and well-being outcomes when compared to participants who were not working (Friedli & WHO, 2009; WHO & Calouste Gulbenkian Foundation, 2014). Paid employment, however, was not something that was readily attained by study participants. Josephine was one such participant:

> *Josephine was born with a physical disability and was soon placed up for adoption. When she made contact with her biological father in her twenties, Josephine was told that her biological parents didn't feel they would have coped with having a child with disabilities. Most of Josephine's early memories involved constant hospital visits, as doctors and her adoptive parents tried to 'fix' her physical impairments. She reflected her adoptive mother was very controlling, and, that this undermined her independence and decision-making*

capacity. Josephine also felt that she wasn't encouraged to think about or develop skills for a future that included work.

Struggles in her teenage years, compounded by disability-related bullying at school, led her adoptive mother to take her to a general practitioner for a mental health assessment. Here, she felt an inaccurate diagnosis and inappropriate treatment manifested in a significant and persistent decline in her mental and physical health. Whilst Josephine finished secondary school, she was not well-supported in her transition into further education and did not complete post-secondary qualifications.

Some years later, the breakdown of her relationship with the father of her child contributed to social isolation, housing insecurity, and, the loss of access to her daughter. Having then experienced sexual violence in rental accommodation, Josephine moved into a disability supported accommodation service, which she was told by staff would be safer. This did not put an end to the sexual violence she experienced. She left the service and moved into public housing tenanted by a friend. The challenge of finding secure and accessible housing continued to be a major barrier to looking for work, and, gaining parental access to be with her daughter.

Despite hundreds of applications and volunteer experience, Josephine has never had paid employment. She attributes this in part to her life circumstances, and, disability-related discrimination within and external to the labour market. In spite of everything she had been through, Josephine has strong work aspirations and sees work as something that would support her independence and sense of connectedness, and, help her be a good role model for her daughter. She voluntarily engaged with DES in the hope they could help her find paid work. Within DES, however, not only did she feel she was not provided with any support, but that she was actively discouraged from pursuing her career aspirations. Josephine also felt DES was having a negative impact on her mental health and personal recovery. Rather than change DES providers, Josephine was considering dropping out of DES, and, giving up on the hope of looking for work altogether.

Josephine's story exemplifies how challenging life circumstances, in interaction with vocational and non-vocational barriers, can undermine career development, mental health, and, personal recovery. These factors in turn make it more difficult to find and maintain work, and, are not readily addressed within the DES program.

10.2 Life circumstances and barriers to employment experienced by DES participants with psychosocial disability

As articulated in *Szymanski and Hershenson's Model,* the career development and employment outcomes experienced by participants in this study were influenced by a broad range of intersecting contextual, individual, cultural and societal level factors and processes across their life courses (Szymanski et al., 2012). As documented in Chapter Six and Seven, key non-vocational barriers identified include socio-economic disadvantage, previous and ongoing experiences of trauma and abuse, bullying and discrimination, unmet need for mental and general health services, and, financial and housing insecurity. These factors are recognised in the broader literature as commonly experienced by people with psychosocial disability, and, undermining of their access to work (Harvey et al., 2016; Morgan et al., 2012; NMHCCF, 2011).

Participants frequently reported recognised vocational barriers to employment, including limited education and post-secondary qualifications (Orygen Youth Health Research Centre, 2014; Simonsen et al., 2013). Disrupted employment histories and negative experiences within the labour market further undermined participants' self-efficacy and confidence to look for work (Eklund, 2007). Whilst the complexity of non-vocational barriers were similarly experienced across the two qualitative cohorts, participants in cohort two were more likely to experience greater vocational barriers to employment such as fewer post-secondary qualifications, limited employment history, and, longer periods of unemployment. This may be reflective of the growing complexity of the broader DES population. DES has seen a rise of more than 80,000 participants since the 2018 reforms. Alongside increasing lengths of unemployment, an increasing proportion of these participants are reported to have psychosocial disability, and, a growing number of participants are reported as homeless, with 'ex-offender' status, and/or, coming from a refugee background (DSS, 2020).

Mainstream employment program research in the Australian context has similarly observed that challenging life circumstances often intertwine with vocational and non-vocational barriers to employment, negatively influencing mental health and well-being, and, undermine engagement with employment programs and the labour market (Harris et al., 2014; O'Halloran et al., 2019; Olney, 2016; Perkins, 2011). This is particularly so in areas where there are limited jobs that met the aspirations, skills and needs of participants. Prior to this study, research on the DES program in relation to psychosocial disability has predominantly focused on the challenges of implementing internationally recognised models of best practice, such as IPS, in the Australian context (Mellifont, 2017; Waghorn & Hielscher, 2015), or, examining how intrinsic traits of participants (e.g. level of

psychosocial functioning) influence employment outcomes (Matthews et al., 2014). My research findings, however, demonstrate the need for DES research to have a wider focus, which includes examination of the life circumstances of participants that may hinder their access to employment.

10.3 Enablers of work for DES participants with psychosocial disabilities

Participants who were currently working were more likely to report they had completed secondary education and attained post-school qualifications. They were also more likely to have previously worked, had fewer disruptions in their work history and, importantly, were less likely to report having experiencing disability-related discrimination in the last 12 months. Qualitative participants who were working, were also more likely to report that greater stability in relation to their mental health and broader life circumstances had made it easier to find and maintain work.

Aligning with *Szymanski and Hershenson's* individual level mediating factors, participants in this study who were working, were more likely to emphasize that individual level intrinsic factors, such as a strong work ethic and motivation to work, had contributed to their employment outcomes than help received within DES (Szymanski et al., 2012). The importance of individual level intrinsic factors has also been observed in other DES and employment program research on what helps people with psychosocial disability gain work (Matthews et al., 2014; Noel et al., 2017; Waghorn et al., 2014). Similar research has shown vocational rehabilitation staff can be trained to implement practices, such as motivational interviewing, which has been shown to enhance the self-efficacy of people with mental illness and increase the likelihood of attaining employment (Craig et al., 2014; Lloyd, Tse, Waghorn, & Hennessy, 2008). Enhancing the capacity of DES workers to utilise motivational interviewing in their practice should therefore be encouraged (J. King & Waghorn, 2018; McDowell, 2018). Yet, such approaches are perhaps more likely to be effective for participants who are experiencing more stability across their broader life circumstances as well.

In this study, participants who found jobs that were congruent with their skills and aspirations, in organisations where the workplace values aligned with those of the individual, were more likely to perceive they would be able to sustain employment, in line with *Szymanski and Hershenson's Model* at the environmental and outcome levels (Szymanski et al., 2012). Similar to other studies, such congruence was also reported as beneficial to mental health and personal recovery, with participants who were working more likely to identify with a greater number of the key dimensions of the *CHIME Personal Recovery Model* (LaMontagne et al., 2016; Leamy et al., 2011; Slade & Longden, 2015; Szymanski et al., 2012). This demonstrates the real value of employment programs

supporting participants into work that is congruent with their vales and aspirations, both in terms of leading to more sustainable employment, and, better mental health outcomes.

It is possible, that participants in this study who had better mental health to begin with, were more likely find and maintain employment, as has been recognised in other DES research (Matthews et al., 2014), and, the broader literature (Slade & Longden, 2015). Nonetheless, the findings demonstrate the important relationship between work and mental health. Understanding of this relationship is essential and helps DES workers tailor more individualised support for participants with psychosocial disability. For example, it could help workers determine which participants would benefit from motivational interviewing and/or a more intense level of mental health support as part of their engagement with DES, or, which participants just need help to pursue work that is congruent with their aspirations and values.

10.4 Mechanisms by which DES providers aim to address barriers to employment

Very few participants who were currently working reported DES directly supported them to attain their current employment. Nonetheless, study participants overwhelmingly reported they wanted support from DES to enhance their confidence in their ability to work, provide individualised advice and support to build skills, as well as help to apply for suitable work. Participants also wanted DES to support them to maintain employment once it was gained. These findings align with other research exploring the (often unmet) expectations and perspectives of DES participants (AFDO, 2014; Nevile & Lohmann, 2011).

Participants in the in-depth interviews described supportive intake processes (e.g. dedicated intake workers that initially meet with participants to understand their needs, support to navigate Centrelink) and internal training offered by some DES providers, as being key mechanisms through which DES could provide support. Importantly, and in terms of the key dimensions identified by the *CHIME Personal Recovery Model,* internal training was described as enhancing social connectedness and peer support, alongside building hope and optimism that attaining work was possible (Leamy et al., 2011). Yet, these mechanisms were inconsistently provided, with cohort two qualitative participants describing that internal training had ceased to be offered by their DES provider post-reforms.

As has been identified by other DES researchers such as King and Waghorn (2018), and, McDowell (2018), participants valued DES workers who took the time to nurture positive relationships, through listening and respecting their aspirations and needs. Participants also appreciated when their DES

worker helped to mutually identify vocational pathways, and, motivated participants to have control over these pathways. The skills of such workers align with those recognised as more effective in the context of DES, and, an area of skills development of the DES workforce requiring greater investment (Giuliani, 2015; J. King & Waghorn, 2018; McDowell, 2018).

Again, supportive relationships with DES workers were inconsistently experienced by participants, with negative experiences that erode mental health commonly reported. This included participants being pushed into jobs that did not align with their skills or aspirations, or, that they felt would negatively impact on their mental health. Such findings are consistent with research on Australia's mainstream employment program, *jobactive,* that found negative treatment within employment services undermines participant well-being and confidence (O'Halloran et al., 2019).

Of the two qualitative cohorts, cohort two participants were more likely to report their DES worker had done more to try and address barriers to employment. For example, supporting participants to try and access community health services to address co-occurring health conditions, or, working with participants to identify transferrable skills if co-occurring physical health conditions prevented them from pursuing the career they were trained and aspired to do. The particular workers described had been working in employment services for extensive periods of time. These findings are therefore more likely to relate to the individual practices of such DES workers, rather than be a product of the reforms.

Positive experiences were, however, also most commonly observed among participants who had more vocational barriers to employment (limited skills or experience), and, had been supported by their DES worker to pursue free further education and training. These findings seem to be more reflective of reform to the Technical and Further Education (TAFE) sector, which saw the Victorian state government introduce free access to certain TAFE courses in January 2019 (which were not available to cohort one participants interviewed prior to both the DES and skills training sector reforms) (Blazevic, 2018; State of Victoria, 2018). The introduction of free courses therefore provided an important vocational pathway for DES workers to refer participants onto, particularly for individuals with limited vocational skills. Similar to research in the vocational rehabilitation sphere, support to pursue vocational training and skills, was perceived by participants as being important to finding work, and beneficial to their mental health (Doroud et al., 2015). Yet, for participants interviewed prior to the introduction of the free courses, or for participants wanting to access non-subsidised courses, course fees were often prohibitive. Furthermore, as discussed in the

following section, access to further education and training does not always equate to improved employment outcomes.

10.5 Factors undermining the effectiveness of DES

Aligning with broader research on Australian employment programs, participants often surmised that the DES program provided more support than the equivalent mainstream *jobactive* program (Mellifont, 2017; Nevile & Lohmann, 2011; Olney, 2016; Perkins, 2011). Yet, the limited skills and capacity of workers, and, inadequate resourcing of DES, still meant that it was difficult for providers to effectively address barriers to work. The high turn-over of staff, exacerbated by the 2018 reforms, meant that participants were often required to change workers (which they were reluctant to do), re-tell their stories, and re-start the process of trying to develop a positive relationship with a new worker. Such processes are known to disrupt the development of positive worker-client relationships, and, can be re-traumatising for many individuals with psychosocial disability who have previous experience of trauma (Danneris & Caswell, 2019; Glendinning, 2008; Sweeney et al., 2018).

Collaboration between employment and mental health services, commonly implemented through Individual Placement and Support (IPS) programs, are increasingly promoted as both more effective at improving employment outcomes for people with mental illness, and, as having the potential to reduce the financial costs associated with the high prevalence of mental illness in Australia (Mental Health Australia & KPMG, 2018; Productivity Commission, 2019a; Western Australian Association for Mental Health, 2019). Yet, there was no evidence shared by participants in this study to suggest the recent reforms had led to enhanced collaboration between DES providers and mental health services. This is despite continual research strongly recommending that the DES reforms do just that (Mellifont, 2017; Parletta, 2015; Waghorn & Hielscher, 2015).

In some cases, participants reported a history of being pushed by employment services (DES and the mainstream *jobactive* program) into inappropriate or precarious jobs. Such situations cause significant distress and undermined work self-efficacy, and, confidence that employment services could help individuals gain and maintain meaningful work (AFDO, 2014; Nevile & Lohmann, 2011; O'Halloran et al., 2019). Others have found that employers are equally frustrated that employment services put forward job applicants without the required skills or experience (O'Halloran et al., 2019; Olney, 2016). This is compounded by the recognised gap in the capacity of DES workers to provide sufficient support to employers to build their knowledge and confidence to employ DES participants (Murfitt et al., 2018).

Whilst the evidence is inconsistent, many researchers highlight the benefit of addressing the gap in employer knowledge and confidence, noting that when employers do have positive experiences of employing people with mental illness, they are generally more willing to hire people from this cohort (Batastini, Bolanos, & Morgan, 2014; Burke et al., 2013; Hand & Tryssenaar, 2006; Murfitt et al., 2018). Conversely, it is reasonable to assume that if DES providers put forward participants without the right skill set, or without providing sufficient support to the employer, this is likely to lead to negative employer experiences and a reduced willingness to employ people with psychosocial disability.

Participants further raised concerns that DES providers were not providing sufficient post-placement support. Support for participants once they gain work is recognised as a crucial component of ensuring people with psychosocial disability maintain employment (Noel et al., 2017; Parletta, 2015; Sherring et al., 2010). This was of specific concern when participants were encouraged into full-time roles (despite only wanting and being required to work part-time), or, into jobs that were not congruent with managing their mental health. The stress of this situation was compounded when they were not able to engage with DES due to the hours of service, or, when DES workers did not follow-up with participants as planned.

Employment services, employers and the wider community were frequently critiqued for their continual under-estimation of the educational and work capacity of participants, as well as ignoring participants' aspirations in relation to the type of work and working arrangements they wanted. This not only eroded mental health, but in some cases led DES workers to undertake negative practices, such as allocating participants into vocational training pathways unlikely to lead to them getting a job (Szymanski et al., 2012). As observed in research by Smith-Merry (2019), people with disabilities are often encouraged (including by DES providers) to cycle through ongoing further education and training courses. Yet, this does not necessarily lead to employment outcomes, particularly in the context of limited availability of jobs (Smith-Merry et al., 2019; Smith-Merry, Buchanan, Yen, Drinkwater, & Smith, 2020).

Of significant concern and reflected in the broader policy sphere, many of the key barriers to employment experienced by participants, fall outside the jurisdiction of DES. Key barriers continue to relate to housing insecurity, even when DES providers try and support participants to access housing services (Aitken et al., 2019; Brackertz et al., 2019; Morgan et al., 2012); inadequate mental

health systems for DES providers to refer participants into (Olney, 2016; Productivity Commission, 2019a); and, persistent financial hardship related to unemployment and the low rate of income support, that is not sufficient to meet basic needs, disability and health related expenses (Collie et al., 2019; Li et al., 2019).

While there is a plethora of federal, state and territory policies and programs relevant to these barriers, they remain ineffectively addressed (Olney, 2016; Perkins, 2011). Alongside the significant issue of the limited availability of jobs, these factors compound mental health conditions and make it more difficult to look for or engage in work, and ultimately, undermine the effectiveness of the DES system (Mellifont, 2017).

10.6 Influence of the NPM-inspired reforms on the DES market

The NPM-inspired reforms to the DES program follow a trend established by many governments to introduce consumer choice into the marketization of welfare services, in an effort to make services more responsive to consumer needs and more efficient and effective in delivering outcomes (Aberbach & Christensen, 2005). Commentators on NPM influenced welfare reform advocate for greater understanding of individual level and market factors which influence individuals' capability for exercising choice and control, particularly those in need of or compulsorily engaged with disability and/or welfare quasi-markets (Clarke et al., 2005; Glendinning, 2008; Jilke, 2015).

The Department of Social Services (DSS) DES program data, indicate there has been an increasing number of individuals entering the DES system (from 193,441 in June 2018 to 273,230 in December 2019). This is alongside a growing complexity of the caseload as describe in section 10.2. Underlying reasons for this may include changes in eligibility criteria and mutual obligation requirements for the DSP, which lead to more people with disabilities being directed onto Newstart, and, more DSP recipients with requirements to engage with DES (Collie et al., 2019; Li et al., 2019; Parliament of Australia, 2018).

The proportion of DES participants who have directly registered with providers (i.e. not through mutual obligations), however, has also increased (8.3% in July 2019, c/w 14.5% in December 2019). So too has the proportion of participants who are voluntarily engaging with DES (19.2% in July 2019, c/w 22.5% in December 2019). It is reasonable to postulate that the increasing numbers of DES participants can in part, be attributed to the DES reform objective of improving the competition and contestability within the DES market (DSS, 2017a). One strategy that DES providers may have used to

counteract their loss of a market share of participants following this reform, may have been to more actively recruit individuals into their services. DES providers may also have been more willing to accept participants with more complex vocational and non-vocational barriers, as a way to retain sufficient numbers to remain viable. The fact that qualitative participants in cohort two were more likely to report higher levels of vocational barriers to employment, alongside their non-vocational barriers, provides support for this hypothesis. This may also be evidenced by the increasing complexity observed within the broader DES population (DSS, 2020).

Whether the increased complexity of the DES population has been matched with increased resourcing through the introduction of the risk-adjusted funding model has been questioned (Cotton, 2019). It was hoped that the new funding model would address issues of 'creaming and parking' previously seen in DES (DSS, 2018a; Nevile & Lohmann, 2011). Yet, study participants continued to perceive inequities within and across what DES services provided, with those more likely to achieve employment outcomes still reported to be prioritised for support. Providers are also continuing to report that clients are often assessed by Centrelink as needing less support than they actually require (Cotton, 2019).

When participants are inappropriately assessed as requiring less funding, it makes it difficult for providers to adequately respond to the needs of complex participants, perpetuating the practice of 'creaming and parking'. It also reduces the likelihood of employment success for individuals with particularly difficult circumstances, and, outcome payments for providers (Cotton, 2019; Nevile & Lohmann, 2011; Olney, 2016). Commentators, such as Cotton (2019), report this is a particular issue experienced by mental health specialist DES providers. Subsequently, mental health specialists are finding it harder to remain viable. This can lead to a reduction of the number of specialists with expert knowledge available to provide services for participants with psychosocial disability (Cotton, 2019).

Indeed, as has been seen in the mainstream *jobactive* employment program, since the introduction of the latest DES reforms, there has been an overall decrease in the number of DES providers. As of January 2020, there were 117 providers compared to 138 at the start of the new DES contract (DSS, 2020). As observed in other employment and disability related quasi-markets, reduced numbers of service providers reduces the number of options available for participants to choose from, thus decreasing competition, contrary to the objective of marketization and the promise of increased 'choice and control' for participants (Glendinning, 2008; McDonald & Marston, 2008).

Exercising of choice and control by DES participants with psychosocial disability

Less than half of all participants in this study reported they had choice in which DES provider they went to. For those who did report control over this decision, participants wanted to choose a provider that was welcoming, who would recognise their strengths, and, was easy to get to. Respondents also wanted a provider with experience with their type of disability, highlighting the importance of ensuring mental health specialist providers remain available within the DES market (Cotton, 2019).

DSS have provided a limited amount of data indicating that 15,827 participants (of the approximately 226,000 total DES population at the time this data was presented) chose to change providers between when the reforms were implemented on 1 July 2018 to 31 March 2019 (DSS, 2019c). With no pre-reform data to compare this to, it is not possible to establish whether this represents an increase in DES participants exercising choice and control to change providers post-reform.

As highlighted by the choice and control narratives in Chapter Eight, only a small number of cohort one qualitative participants chose to '*actively stay'* with their provider. Participants actively staying were more likely to report being matched with an employment consultant they felt was empathetic to their circumstances, and, more respectful of their aspirations than previous consultants. They were, however, also more likely to want to defer decision-making responsibility both within and external to DES. Actively choosing to stay was still a very inconsistent scenario observed within this study, and, the wider body of DES research (AFDO, 2014; Corbière et al., 2014; J. King & Waghorn, 2018).

Cohort two participants were mapped to the choice and control narratives subsequent to the paper forming Chapter Eight being published. Whilst the numbers are small and definitive conclusions are not possible, cohort two participants were more likely to be *'actively staying'* with their current provider when compared with cohort one. Cohort two participants did appear to be more aware that they were able to change providers if they were not happy. Indeed, a small number of these participants had exercised choice to change providers just prior to the initial interview. This was often described as being precipitated by very negative experiences with their previous DES provider, whereby they felt they had no choice but to change. Participants in this group were also more likely

to be experiencing vocational barriers, and, felt they had been supported to access free further education or training (through the Victorian state government TAFE reforms) by their current provider. Their appreciation of this support to access further training, may have made it more likely that they would actively stay with their provider.

The majority of individuals across the two qualitative cohorts, however, were not exercising choice and control to change providers and were overwhelmingly found to be *'passively*' or *'reluctantly staying'* with their provider. This was despite dissatisfaction with the services received, the fact that outcomes were not being achieved, and in some cases, when DES was seen to be detrimental to their mental health. No cohort two participants were mapped to the '*tinkering on the edge of change'* narrative. However, one participant did actively exercise choice and control to change providers due to dissatisfaction with the services received. This participant was encouraged and supported to change providers by their NDIS disability support worker. This example highlights the importance of support mechanisms to enable people with psychosocial disability to exercise choice and control within the context of DES. Nonetheless, despite being supported to exercise choice and control to change DES, the participant subsequently dropped out of DES altogether due to deteriorating mental health as a consequence of housing insecurity.

Importantly, there are no findings from my research or DSS program data to suggest that exercising choice and control to stay with or change providers leads to improved employment outcomes. DES program data indicates employment outcomes continue to fluctuate with no real improvement in outcomes achieved since the reforms were implemented, suggesting that broader factors continue to undermine employment outcomes for DES participants (DSS, 2020).

Factors influencing choice and control in the context of DES

The findings from this study highlight a multitude of intersecting factors that undermine mental health, engagement with DES, and, desire and capability to exercise choice and control within the context of DES. Similar to what has been observed in other quasi-market and disability research, choice and control for participants in this study was influenced by the interaction of life circumstances with their level of satisfaction with their current provider (often in comparison to previous experiences with employment services), and, knowledge and information on the right to and how to change providers (Brophy, Bruxner, & Wilson, 2014; Clarke et al., 2005; Glendinning, 2008; Nevile & Lohmann, 2011; Warr et al., 2017).

Key barriers to exercising choice and control within this study and the above mentioned research, included low expectations of their entitlement to adequate services, a perception that all providers were the same, and, a fear of having to re-tell their story to a new provider if they changed (Glendinning, 2008; Van de Walle & Marien, 2017; Warr et al., 2017). Limited availability of jobs, coupled with a need to focus on addressing more pressing needs (such as safety and housing) as opposed to looking for work or changing providers, further undermined motivation to actively exercise control to change providers, despite recognising that outcomes were not being achieved.

The notion that participants are truly able to exercise choice and control in the context of a system where most participants are compulsorily engaged through mutual obligations to remain in receipt of income support, remains contested (Marston et al., 2016; Nevile, 2012) Nonetheless, choice and control within the DES market is still something that is valued by many DES participants, meaning it is important to ensure DES policy makers and providers don't allow it to become completely empty rhetoric, and that providers ensure they are doing what they can to support participants to exercise the limited choice and control that is available to them (Marston et al., 2016). Recognising the capacity of people with psychosocial disability to make decisions about their own lives, albeit that some people desire and require support, is fundamental to promoting choice and control within the marketization of employment and/or disability related policies and programs such as DES (Brophy, Bruxner, Wilson, et al., 2014; Knight et al., 2018). This is particularly so as enhancing choice and control is so important to the personal recovery of people with psychosocial disability, which in turn can facilitate access to work (Eklund, 2007; Leamy et al., 2011; Slade et al., 2014).

Supporting choice and control requires provision of readily accessible and useful information to help participants differentiate between services and choose a service they identify as best meeting their needs (AFDO, 2014; Dan & Andrews, 2016; Glendinning, 2008; McDonald & Marston, 2008). The federal government's *jobaccess* online platform does offer a search engine for participants to identify providers in their area and see what their current star rating is. Or, participants can review the 174 page listing of star ratings by provider site (Department of Social Services, 2020). This information, however, was only made available by the government one year after the reforms were implemented. Alongside more accessible government provided information, supporting choice and control within the context of DES, requires providers to better enable participants to draw on formal and informal support networks as desired to support decision-making within DES (Shaw et al., 2004). Moreover, it requires broader social policies to help address the challenging and complex life circumstances experienced by DES participants with psychosocial disability which compound barriers

to employment, and, hinder the desire and capacity for choice and control (Nevile & Lohmann, 2011; Parent, 1996).

10.7 The influence of DES on the life circumstances of DES participants with psychosocial disability

This study confirms that engagement with the DES program inconsistently leads to employment outcomes for DES participants with psychosocial disability. Very few participants in this study were working, and even fewer of those who were felt DES had directly helped them into work. Participants who were working were found to have better mental health and well-being, compared to participants who were not. Concurring with the literature which highlights the relationship between work and mental health, this was particularly so for participants working in jobs aligning with their skills, aspirations and needs, in organisations that were congruent with their values (Milner et al., 2014; Slade & Longden, 2015; Szymanski et al., 2012). Yet it was not possible to determine whether people who are supported by DES into work, go on to sustain employment, and, experience improvements in other aspects of their lives, such as financial security and housing stability.

Nonetheless, as highlighted in Chapter Nine, these findings do demonstrate that engagement with DES can have an influence the mental health and personal recovery of participants. Some participants clearly experience personal recovery regardless of their engagement with DES. Such participants more readily identified experiencing stability in relation to their life circumstances. This in turn aligned them with more of the key dimensions of the *CHIME Model of Personal Recovery* (Leamy et al., 2011). For example, improvements and/or stability in family relationships contributed to less stress and feelings of connectedness, and, overcoming challenges related to their mental health contributed to both their sense of identity and empowerment. These participants were also more likely to report that their intrinsic traits had helped them secure their own employment. Recovery was further supported when participants were in roles that aligned with their skills, aspirations and values (Szymanski et al., 2012).

For others, engagement with DES was positioned as directly supporting personal recovery. This was achieved when frontline workers utilised approaches that align with recovery-orientated practices. (Corbière et al., 2014; J. King & Waghorn, 2018). As emphasised in the *CHIME Personal Recovery Model,* the work of Salzer and Baron (2016) and of King and Waghorn (2018), such approaches recognise and value the skills and aspirations of participants, nurturing positive working-alliances, and, collaboration with participants to identify skills and aspirations. Participants similarly valued

workers that proactively tried to address complex barriers to employment, and, motivated and supported them to pursue vocational education and training (Doroud et al., 2015).

In comparison, there were participants whose engagement with DES undermined their mental health. These participants in no way positioned DES as enhancing any of the dimensions of *CHIME* on their journeys of recovery (Leamy et al., 2011). Indeed, similar to what has been observed by other DES commentators, these participants perceived that engagement with DES actually undermined their access to meaningful employment by disregarding their aspirations and/or pressuring them into training and jobs that did not align with their skills (AFDO, 2014; Nevile & Lohmann, 2011).

Whilst numbers are small, participants from cohort two were more likely to identify that engagement with DES had positively contributed to their mental health. As highlighted above, this was particularly so for participants who had greater vocational barriers and had been supported to access free further education and training. As such, it seems the reforms to the TAFE sector played a more important role than the DES reforms, in enabling DES workers to refer participants into a vocational pathway.

It should also be noted, that more cohort two participants dropped out of DES and/or the study at the time of follow-up. These participants were experiencing significantly more complex mental health conditions and life circumstances, which may have made it more difficult for them to remain engaged with DES or to be adequately supported by DES. Had these participants been interviewed at follow-up, it may have influenced the comparisons between how participants across the two cohorts were mapped to the narratives of recovery.

Nonetheless, the most common experience observed across the two qualitative cohorts, is that the majority of study participants were just surviving regardless of their engagement with DES. Most of these participants were really struggling to access sufficient services and supports (within and external to DES), to enable them to address their mental health needs or challenging life circumstances. Echoing previous research, concern was also raised regarding the limitations of DES frontline workers to adequately support participants experiencing mental illness, highlighting a need to develop basic skills in counselling, motivational interviewing, and, more individualised support (AFDO, 2014; Cotton, 2019; McDowell, 2018). Until these issues can be addressed, the effectiveness of DES to support people with psychosocial disability into employment will remain limited.

10.8 Implications for DES policy and practice

Given the increasing number of people with psychosocial disability entering the DES system, there is a clear imperative to encourage greater consideration of recovery-orientated approaches within DES policy and practice. International research, such as that conducted by Corbière (2014), and, research within the Australian DES context by King and Waghorn (2018) and McDowell (2018), demonstrates that employment consultants can develop and implement approaches that better align with recovery-orientated practice and which lead to improved employment outcomes. This includes utilising positive working alliances with job seekers; incorporating psychological interventions within employment supports; motivational interviewing; and, working with employers to actively encourage and support them to employ people with psychosocial disability (Corbière et al., 2014; J. King & Waghorn, 2018; McDowell, 2018).

It has been noted by others that the lack of standards for the skills and qualifications of the DES workforce continues to undermine the effectiveness of DES, particularly in regards to supporting participants with psychosocial disability (Giuliani, 2015; McDowell, 2018; Parletta, 2015). Facilitating recovery-orientated approaches within DES would therefore require significant upskilling of the workforce. Alongside this is a need to support the viability of mental health specialists within the DES system (Cotton, 2019; Mellifont, 2017). Determining what policy and market levers would enable the upskilling of the DES workforce, and more support for mental health specialists, requires further consideration by DSS and DES providers. Potential levers may include examining how the current risk-adjusted funding and performance frameworks could be implemented more equitably (e.g. more accurate assessments of participant needs) to ensure DES mental health specialists were sufficiently resourced to provide appropriate levels of support to participants with psychosocial disability (Cotton, 2019).

Recovery-orientated approaches within the context of DES require more considered intake processes. This would support providers to match participants with employment consultants that are best placed to meet their needs, and, be more enabling of positive worker-client alliances (Giuliani, 2015; J. King & Waghorn, 2018). Greater provision of services and supports that DES participants value is similarly recommended. This includes internal training that builds the confidence, skills and empowerment of participants, and, encourages connections and peer support in aid of recovery (Bird et al., 2014). Ensuring positive worker-client alliances are extended through flexible post-placement support is likewise crucial to support participants overcome challenges within the workplace. Post-placement support is also vital to ensuring the ongoing career and skill

development of participants, so they are able to pursue short and longer term career aspirations. (Szymanski et al., 2012). All these strategies require DES providers and workers to open themselves up to learning from the perspectives of DES participants, as to how services can continually evolve to better meet the diverse needs and expectations of the individuals they work with (Clarke et al., 2005).

Whilst challenging within the context of increasing marketization of the DES program, and, where it is unlikely we will see a shift away from compliance driven welfare policies, it remains vitally important that the DES program does more to empower participants to exercise the choice and control that is afforded to them within the program (Marston et al., 2016; Nevile, 2012). This should extend beyond participants' choice and control over which provider they access, to having more control over the services and supports they receive within DES. Ideally, this would enable participants to expect to receive supports that help them to work towards self-determined employment goals, and, to exercise choice and control to change services if these expectations are not met (AFDO, 2014). Central to this is greater provision of accessible information on the right to exercise choice and control within DES; more timely and differentiating information on providers within the DES market to better enable participants to determine which provider may best meet their needs; and, ensuring participants have access to resources that support and nurture their decision-making processes (e.g. enabling participants to draw on support networks to help them navigate choice and control within the DES program) (Brophy, Bruxner, Wilson, et al., 2014).

Finally, widely recognised by DES researchers and commentators, and, a growing number of mental health and economic institutions (e.g. Australia's Productivity Commission), the DES program does need to do more to enable the implementation of models which better integrate mental health and employment services, such as Individual Placement and Support (IPS) (Mellifont, 2017; Mental Health Australia & KPMG, 2018; Parletta & Waghorn, 2016; Productivity Commission, 2019a; Waghorn & Hielscher, 2015). An increasing number of models of IPS are being operationalised in Australia by mental health services, often with the support of employment specialists and/or DES providers (Dawson & Muller, 2019; Scanlan et al., 2019). Indeed, DSS are currently trialling IPS within their Youth Employment programs (DSS, 2019a; Western Australian Association for Mental Health, 2019). Yet, an expansion of such programs could also be driven within and by the DES program. Examining ways in which DSS and the DES market could draw on existing DES innovation funding opportunities to facilitate the expansion of such programs is paramount (Mellifont, 2017).

Opportunities may also exist in examining how the intersection between the DES program and the NDIS could further facilitate the expansion of IPS models for job seekers with psychosocial disability.

However, even with an enhanced focus on recovery-orientated approaches within DES, and better integration of mental health services and the DES program, effectiveness of the program will likely continue to be undermined by the challenging life circumstances often experienced by people with psychosocial disability. The next section highlights broader policy considerations within the Australian context that therefore require greater investment, in order to more effectively address the vocational and non-vocational barriers to work experienced by people with psychosocial disability, and support more individuals within this cohort to attain their right to work.

10.9 Broader policy considerations

There is no doubt that Australia is experiencing a crisis across our mental health systems, which are stretched beyond breaking point and failing to provide adequate support to the growing number of people with mental illness (NMHCCF, 2011; Productivity Commission, 2019a; State of Victoria, 2019b). Far greater investment in mental health is therefore urgently required. Experts agree this should be targeted at expanding community mental health programs, and, the provision of more coordinated responses to address the mental and general health needs of people with mental health conditions and illness, before their conditions become more disabling. More investment is also needed to support the clinical and personal recovery of people when they do experience more disabling conditions (COAG, 2017; NMHCCF, 2011; Slade et al., 2014; State of Victoria, 2019b).

Improving mental health and well-being also requires the persistent socio-economic disadvantage and health inequalities that particularly affect people with disabilities to be addressed (Aitken et al., 2019; Kavanagh et al., 2016; Kavanagh et al., 2015; Mithen et al., 2015). If left unaddressed, socio-economic inequalities will continue to create barriers to education, housing, employment and financial security (Lund et al., 2018). This then leads to a disabling cycle of poor mental health, reduced access to employment, and worsening socio-economic circumstances (Lund et al., 2018). Until Australian policies and programs across the areas of health, education, housing, welfare, and, employment, can adequately address this cycle, we cannot expect people with disabilities to benefit as much as they should from the DES programs. Pointedly, this includes raising the rate of income support currently provided to unemployed Australians, to ensure that all income support recipients

with and without disabilities, can meet their basic needs as a fundamental requirement of gaining and maintaining employment (ACOSS, 2018; McClure et al., 2015).

Addressing socio-economic inequalities experienced by people with disabilities, may in part be achieved as the NDIS continues to mature, at least for the ten per cent of the Australian population with disabilities earmarked to benefit from access to the NDIS (Bonyhady, 2014). Yet, the NDIS is not designed to meet the needs of all Australians with disabilities. Furthermore, not only do people with psychosocial disability continue to be underrepresented within the scheme, operationalisation of the NDIS has seen a significant disruption in the delivery of mental health services and programs, negatively impacting on people with psychosocial disability, whether within or excluded from the NDIS (Joint Standing Committee of the NDIS, 2017; Productivity Commission, 2019a; Smith-Merry et al., 2018).

This situation underscores the need to think more broadly about how to reform Australia's disability system, of which the NDIS is one component. As argued in a recent White Paper tabled by The University of Western Australia (2019), we cannot continue to tinker at the edges of the NDIS market and expect it to adequately meet the needs of the Australian population with disabilities. Instead, Australian governments, people with disabilities and their families, and communities, need to come together to collaboratively reform the broader disability system, to provide clarity and transparency over roles and responsibilities, and, flexibility in policy and practice to meet the diverse needs of people with disabilities in the diverse contexts in which they live (Gilchrist et al., 2019). This is timely advice given Australia is set to introduce a new National Disability Strategy and National Disability Agreement in 2020, both of which will aim to better coordinate roles, responsibilities and funding for disability policies across all levels and domains of government (Productivity Commission, 2019b).

Underpinning any policy action to progress the rights of people with psychosocial disability, is the need to promote better understanding of mental illness, disability, and, positive expectations in support of recovery, among individuals, families, communities, employers and governments (GIZ & CMB, 2012; Keogh & Down, 2014; Salzer & Baron, 2016). This includes the fact that not only do the majority of people with psychosocial disability want to work, but that they have the right to work (Provencher et al., 2002; UN General Assembly, 2006), and, with the right supports available to help individuals gain and maintain employment, they have the capacity to work. Work in turn can play an important role in clinical and personal recovery (Slade & Longden, 2015). Furthermore, helping people with psychosocial disability into work will lead to socio-economic benefits for individuals, families and communities (Mental Health Australia & KPMG, 2018; OECD, 2009).

Finally, and absolutely critical to the effectiveness of the DES program, is inclusive job creation (OECD, 2017; Smith-Merry et al., 2020). Globally, the nature of work continues to change, with numerous factors creating both challenges and potential opportunities for local labour markets and individuals trying to engage with these markets. This particularly impacts on job seekers with disabilities (Canivet et al., 2016; Frasquilho et al., 2015; Szymanski et al., 2012; Szymanski & Vancollins, 2003). Globalisation, the rise of automation and Artificial Intelligence, economic uncertainty, pandemics, the changing and sometimes declining opportunities within markets that the Australian economy has so heavily relied upon (e.g. mining, manufacturing), the aging of populations, as well as an increasing recognition of the need to address and mitigate climate change all influence how labour markets function and interact with each other (Bates, Goodley, & Runswick-Cole, 2017; Canivet et al., 2016; Fankhaeser, Sehlleier, & Stern, 2008; Frasquilho et al., 2015; OECD, 2017; Szymanski et al., 2012).

Within this increasingly complex context, governments and societies must radically shift their thinking away from blaming individuals for not doing more to promote their employability, towards fixing systems and labour markets, to enable job creation that meets the diverse needs, skills and aspirations of the increasing number of people with psychosocial disability wanting (and mutually obligated) to work. As so eloquently described below by one participant, when enough jobs just do not exist, no amount of resilience training is going to help people with psychosocial disability outcompete each other to gain work. Making them do so only compounds the disadvantage that makes it harder for them to compete in the first place.

> *So these platitudes you have to be more resilient and all this and that, and we sit out there and* [employment consultant] *tells us everything we are doing wrong, and people sit there and agree and soak up all this narrative that it's our fault. And it gets to me … I dunno, if you were to improve a place like this as far as I'm concerned, it would have plastered on the wall, 'It's cool', 'It's not your fault this country is so messed up right now', 'Let's try and fix the country'. But that's completely antithetical to and sort of lends itself to pop psychology. Like this resilience thing. There might be something to it but I'm not sure … Rather than spending a couple of billion dollars a year yelling at people and getting people to out grovel each other, if there was guaranteed employment … It's up to them to find something meaningful for people to do. Rather than say that there is nothing there for 5 per cent of society, therefore it is that 5 per cent of the population's fault. If there is nothing for that 5 per cent of the population to do, therefore we had better think of something.* (P21)

10.10 Strengths and limitations

The IDES survey is the first Australian study that draws on existing validated instruments and specifically developed items, to comprehensively examine factors that influence access to employment from the perspectives of DES participants themselves. The survey was, however, implemented during a time of considerable uncertainty in the DES sector. This resulted in a smaller than expected sample recruited into Wave 1 of the IDES survey, despite an extended recruitment period. Drawing from a relatively small number of DES providers (approximately 7.5% of the current market), only offering the survey in English, and, requiring participants to opt into the survey, may have resulted in a sample that is not as representative of the wider DES population as anticipated. Further, the longer than expected time taken to complete Wave 1, meant that it was not feasible to analyse data from Wave 2 in this thesis. Doing so would have allowed me to more fully investigate how life circumstances, employment and mental health may change the longer people are engaged with DES.

Compared to the DES population, participants in this study were younger, more likely to be female, and, were less ethnically diverse. The findings may therefore not represent the intersectional disadvantage people with psychosocial disability who are older and/or from non-English speaking backgrounds may experience within the Australian labour market (AHRC, 2016; Federation of Ethnic Communities' Councils of Australia & Inc, 2015). Participants were also recruited through a relatively small number of DES providers. Their experiences of services may therefore not be representative of alternative models of services available in the wider DES market.

Qualitative participants were interviewed at two points in time, with approximately six months between the initial and follow-up interview. This was a sufficient amount of time to explore changes occurring at an individual level, as well as gain a preliminary understanding of changes occurring across the DES sector post reforms. The life stories of participants will nonetheless continue to evolve, and mostly likely, continue to be influenced by their engagement with DES. A longer timeframe may have allowed for further follow-up with participants and a richer understanding of their experiences. Considerable time was spent with DES providers which enabled me to test whether my analysis resonated with DES frontline and managerial staff. Whilst beyond the scope of what was feasible in this study, directly collecting data from DES providers would have, however, allowed for further triangulation.

It should also be noted that whilst de-identified transcripts were shared with the research team to enable their input into the refinement of the thematic coding frameworks, I was the only researcher to review, code and analysis all transcripts. Similarly, whilst emerging findings were shared on a continual basis with the research team, having a second coder review all transcripts, may have elicited further themes, and/or, helped concur agreement with my own analysis. Despite these limitations, the thesis make an important contribution to the understanding of the relationships between life circumstances, barriers and facilitators to work, employment outcomes, and, the mental health of people with psychosocial disability engaged in the ever-reforming DES program. In turn, these findings clearly highlight for policy makers and providers, factors within and external to DES, which influence the effectiveness of the DES program.

This study was further strengthened by the utilisation of two conceptual frameworks: Szymanski and Hershenson's *Ecological Model for Vocational Behaviour and Intervention for People with Disabilities,* and, the *CHIME Personal Recovery Model*. Integration of these frameworks was critical as neither alone enabled sufficient exploration of factors occurring across the life course that influence the dynamics between life circumstances, mental health, career development, and engagement with employment programs and the labour market. For example, whilst *Szymanski and Hershenson's Model* takes a life course and ecological approach, it doesn't have a specific focus on mental health and recovery, and, how these are influenced by engagement with employment programs and the labour market. Whereas, whilst the *CHIME Model* recognises employment as a key element facilitating dimensions of recovery for many people with psychosocial disability, it doesn't examine processes across the life course that influence the dynamics of interest highlighted above. As such, integration of the frameworks enabled me to examine the different dimensions of mental health recovery proposed within the *CHIME Model,* across the ecological constructs and life course processes influencing career development and employment within *Szymanski and Hershenson's Model*. This approach could be similarly implemented my own future research on disability and employment, and, that of others.

10.11 Future research

There are a number of future research ideas stemming from this research. First and foremost is analysis of the IDES Wave 2 data. This will focus on comparisons between the two waves of data to examine changes in employment, mental health and the socio-economic circumstances of participants over time. Specifically, I hope to explore whether gaining and maintaining work leads to

changes in socio-economic conditions and life circumstances, and if this in turn leads to improved mental health and well-being. Wave 2 includes items which will enable me to explore whether participant expectations of DES services and supports are being met, and what services and supports are more likely to facilitate sustainable employment outcomes. It will also enable me to examine whether the choice and control narratives identified in the qualitative component of this study, are reflected in subsequent analysis of the Wave 2 data.

Furthermore, the choice and control and recovery narrative frameworks developed as part of this study, provide useful propositions for ongoing monitoring and evaluation of the DES program. They will be likewise useful for researching participant perspectives on their experiences within other programs. This includes programs which have similarly been influenced by theories of NPM, such as the NDIS. On this note, I have received seed funding to further explore the interface between the DES program and the NDIS. Alongside analysis of IDES Wave 2 data to examine whether more DES participants are gaining access to the NDIS, and, if this influences access to employment outcomes, this funding will be used to consult with key stakeholders (e.g. government and NDIA representatives, employment provider peak bodies, and agencies involved in the delivery of the NDIS), DES providers, and, NDIS participants engaged with the DES program to understand more about the DES/NDIS interface.

Additionally, the NDIA are increasingly investing in efforts to bolster employment outcomes of NDIS participants through their Information, Linkages and Communications funding stream (National Disability Insurance Agency, 2020). It will be important to monitor whether and how such investments lead to improvements in employment outcomes of NDIS participants, and, if projects are shown to be effective, how can this lead to scalable programs that improve employment outcomes for Australians with disabilities more broadly. Similarly, it is important to monitor whether the implementation of IPS programs continues to be expanded through Australia's mental health system, and, whether this leads to improved employment outcomes of people with mental illness and psychosocial disability. If it does, factors that would enable more DES providers to implement IPS should be explored.

Ongoing research into the socio-economic disadvantage, health inequalities and poorer employment outcomes of Australians with disabilities, and, whether policies and programs are addressing these issues, remains of critical importance. As is ongoing research on how Australian governments and communities can actually promote inclusive job creation, whether this be through tax incentives, preferential government contracting for organisations they employ people with disabilities, employment quotas, greater investment in social enterprise, or, more support to encourage

employers to employ people with disabilities (Murfitt et al., 2018; Murfitt, Zammit, Bryant, Strachan, & Williams, 2017; Saleh & Bruyère, 2018).

Finally, this PhD study was embedded within the ARC funded IDES project. It was implemented by the University of Melbourne in partnership with service provider peak bodies, employment service providers and disability advocacy bodies, including the Australian Federation of Disability Organisations. Throughout the study, the researcher and broader research team discussed and disseminated findings with partners, research participants, and, the wider practitioner and research communities. Given the aims and objectives of the IDES project and the PhD study, alongside the time and resource constraints of embedding a PhD a broader project, it was not feasible to implement more inclusive, participatory methods. There is, however, opportunity to ensure future research in this area enables greater participation of people with psychosocial disability in identifying, designing and implementing research that addresses their key concerns.

10.12 Final conclusions

Many people with psychosocial disability want to work, and, having access to work can be of significant benefit to their mental health and broader life circumstances. Despite ongoing reform, this study concludes that the DES program remains hindered in its capacity to support participants with psychosocial disability to address the challenging life experiences, and, vocational and non-vocational barriers to employment that they so often experience. These same circumstances undermine the mental health recoveries of DES participants, and, their capabilities to exercise the relatively limited choice and control afforded to them within the DES program. Even if people do exercise choice and control within the context of DES, there is little evidence to suggest this will lead to improved employment outcomes.

The DES system can only be effective within a broader context of policies, programs and environments that better promote the mental health and well-being of our populations, and, better support people when they do become unwell. This is alongside an urgent need to address structural barriers to employment such as disability-related discrimination. Critically, Australian governments and communities, need to do much more in the area of inclusive job creation, to address the dearth of jobs that fit the skills, aspirations and needs of the growing number of people with disabilities wanting (and mutually obligated) to find and maintain meaningful employment. Fundamental to this is creating a society that more fully understands and respects the rights of all Australians with

disabilities, such as Josephine, to live, participate and work in their communities on an equal basis with others.

References

Aberbach, J. D., & Christensen, T. (2005). Citizens and consumers: An NPM dilemma. *Public Management Review, 7*(2), 225-246.

Aitken, Z., Baker, E., Badland, H., Mason, K., Bentley, R., Beer, A., & Kavanagh, A. M. (2019). Precariously placed: housing affordability, quality and satisfaction of Australians with disabilities. *Disability & Society, 34*(1), 121-142.

Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry, 26*(4), 392-407.

Anglicare Australia. (2019). *Rental Affordability Snapsot*. Retrieved from https://www.anglicare.asn.au/our-work/research-reports/the-rental-affordability-snapshot/

Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11-23.

Anthony, W., & Mizock, L. (2014). Evidence-based processes in an era of recovery: Implications for rehabilitation counseling and research. *Rehabilitation Counseling Bulletin, 57*(4), 219-227.

Arstein-Kerslake, A. (2017). *Restoring Voice to People with Cognitive Disabilities*. New York: Cambridge University Press.

Arstein-Kerslake, A., Watson, J., Browning, M., Martinis, J., & Blanck, P. (2017). Future Directions in Supported Decision-Making. *Disability Studies Quarterly, 37*(1).

Australian Bureau of Statistics. (2008). *National Survey of Mental Health and Wellbeing 2007: Summary of Results. Cat. no. 4326.0*. Retrieved from https://www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0

Australian Bureau of Statistics. (2015a). *Survey of Disability, Ageing and Carers, Australia*.

Australian Bureau of Statistics. (2015b). *Survey of Disability, Ageing and Carers. Household Survey Questionnaire*. Retrieved from https://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/8F411A618C3CD63DCA25804F000F60CD/$File/attk7lrm.pdf.

Australian Bureau of Statistics. (2016). *Disability, Ageing and Carers, Australia: Summary of Findings, 2015.*

Australian Bureau of Statistics. (2018). *National Health Survey First results Australia 2017-18. cat 4364.0.55.001*. Retrieved from https://www.abs.gov.au/ausstats/abs@.nsf/mf/4364.0.55.001

Australian Bureau of Statistics. (2019). *Disability, Ageing and Carers, Australia: Summary of Findings, 2018. Cat. 4430.0*. Retrieved from https://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0

Australian Chamber of Commerce and Industry. (2014). *Employ outside the box: The business case for employing people with disability*. Retrieved from https://www.australianchamber.com.au/wp-content/uploads/2018/01/eotb_-_main_a4.pdf

Australian Chamber of Commerce and Industry. (2017). *Comments on the Discussion Paper on the new Disability Employment Services from 2018*. Retrieved from https://engage.dss.gov.au/disability-employment-services-reform/disability-employment-services-reform-public-submissions/

Australian Council of Social Services. (2018). *Raise the Rate Fact Sheet 4*. Retrieved from https://www.acoss.org.au/raisetherate/

Australian Federation of Disability Organisations. (2014). *Consumers front and centre: What consumers really think about Disability Employment Services.* Retrieved from http://www.daru.org.au/resource/consumers-front-and-centre-what-consumers-really-think-about-disability-employment-services

Australian Government. (2018). *Targeted Compliance Framework: Work Refusal and Unemployment Failures Guidelines*. Canberra.

Australian Government. (2019). *Budget Paper No. 1: Budget Strategy and Outlook 2019-20*. Retrieved from https://www.budget.gov.au/2019-20/content/bp1/index.htm

Australian Health Ministers' Advisory Council. (2013). *A national framework for recovery-oriented mental health services: Guide for practitioners and providers.* Canberra: Commonwealth of Australia.

Australian Human Rights Commission. (2016). *Willing to Work. National Inquiry into Employment Discrimination Against Older Australians and Australians with Disability.* Retrieved from https://www.humanrights.gov.au/our-work/age-discrimination/projects/willing-work-national-inquiry-employment-discrimination

Australian Institute of Health and Welfare. (2016). *Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011.* Retrieved from https://www.aihw.gov.au/reports/burden-of-disease/abds-impact-and-causes-of-illness-death-2011/contents/highlights

Australian Institute of Health and Welfare. (2017). *Disability in Australia: changes over time in inclusion and participation in employment*. Canberra.

Australian Institute of Health and Welfare. (2018). *Mental health services—in brief 2018.* Retrieved from www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia-in-brief-2018

Australian Institute of Health and Welfare. (2019a). *Mental health services—in brief 2019*. Retrieved from https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia-in-brief-2019/

Australian Institute of Health and Welfare. (2019b). Mental Health Services in Australia. Psychiatric Disability Support Services 2017-18. Retrieved from https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/psychiatric-disability-support-services

Australian Institute of Health and Welfare. (2019c). People with disabilities in Australia. Retrieved from https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia

Australian Institute of Health and Welfare. (2019d). *Specialist homelessness services annual report 2017-2018.* Retrieved from www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-2017-18/

Barabasch, A. (2018). The narrative approach in research and its use for policy advice. *International Journal of Lifelong Education, 37*(4), 468-481.

Batastini, A., Bolanos, A., & Morgan, R. (2014). Attitudes toward hiring applicants with mental illness and criminal justice involvement: The impact of education and experience. *International Journal of Law and Psychiatry, 37*(5), 524-533.

Bates, K., Goodley, D., & Runswick-Cole, K. (2017). Precarious lives and resistant possibilities: the labour of people with learning disabilities in times of austerity. *Disability & Society, 32*(2), 160-175.

Baume, P., & Kay, K. (1995). *Working solution: Report of the strategic review of the Commonwealth Disability Services Program*: Australian Government Pub. Service.

Beck, V. (2018). Capabilities and choices of vulnerable, long-term unemployed individuals. *Work, Employment and Society, 32*(1), 3-19.

Benach, J., Muntaner, C., & Santana, V. (2007). *Employment conditions and health inequalities. Employment Conditions Knowledge Network (EMCONET), World Health Organisation*. Retrieved from https://www.who.int/social_determinants/resources/articles/emconet_who_report.pdf

Bentley, R., Kavanagh, A., Krnjacki, L., & LaMontagne, A. (2015). A Longitudinal Analysis of Changes in Job control and Mental health. *American Journal of Epidemiology, 182*(4), 328-334.

Bird, V., Leamy, M., Tew, J., Le Boutillier, C., Williams, J., & Slade, M. (2014). Fit for purpose? Validation of a conceptual framework for personal recovery with current mental health consumers. *Australian & New Zealand Journal of Psychiatry, 48*(7), 644-653.

Blazevic, O. (2018). Victoria the Education State, Free TAFE courses. Retrieved from https://www.tafecourses.com.au/resources/victoria-the-education-state-free-tafe-courses/

Blustein, D. L. (2008). The role of work in psychological health and well-being: a conceptual, historical, and public policy perspective. *American Psychologist, 63*(4), 228.

Bonyhady, B. (2014). Tides of change: The NDIS and its journey to transform disability support. *The Australian Journal on Psychosocial Rehabilitation, 7*(1), 7-9.

Brackertz, N., Davidson, J., & Wilkinson, A. (2019). *Trajectories: the interplay between mental health and housing pathways, a short summary of the evidence, report prepared by AHURI Professional Services for Mind Australia, Australian Housing and Urban Research Institute.* Retrieved from https://www.ahuri.edu.au/__data/assets/pdf_file/0010/40303/Trajectories-the-interplay-between-mental-health-and-housing-pathways.pdf

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Brophy, L., Bruxner, A., & Wilson, E. (2014). Consumer choices about mental health support services. *New paradigm*(Summer 2014), 27-29.

Brophy, L., Bruxner, A., Wilson, E., Cocks, N., Stylianou, M., & Mitchell, P. (2014). *People making choices: The support needs and preferences of people with psychosocial disability* (0646931873). Retrieved from https://www.mindaustralia.org.au/sites/default/files/People_making_choices_summary_research_report.pdf

Brown, D. (2007). *Career Information, Career Counseling, and Career Development* (9 ed.). Boston: Pearson/A&B.

Brown, K., Hoye, R., & Nicholson, M. (2012). Self-esteem, self-efficacy, and social connectedness as mediators of the relationship between volunteering and well-being. *Journal of Social Service Research, 38*(4), 468-483.

Bruner, J. (1991). The narrative construction of reality. *Critical Inquiry, 18*(1), 1-21.

Burchardt, T., Evans, M., & Holder, H. (2015). Public policy and inequalities of choice and autonomy. *Social Policy & Administration, 49*(1), 44-67.

Burke, J., Bezyak, J., Fraser, R. T., Pete, J., Ditchman, N., & Chan, F. (2013). Employers' attitudes towards hiring and retaining people with disabilities: A review of the literature. *The Australian Journal of Rehabilitation Counselling, 19*(1), 21-38.

Bush, P. W., Drake, R. E., Xie, H., McHugo, G. J., & Haslett, W. R. (2009). The long-term impact of employment on mental health service use and costs for persons with severe mental illness. *Psychiatric Services, 60*(8), 1024-1031.

Butterworth, P., Leach, L., McManus, S., & Stansfeld, S. (2013). Common mental disorders, unemployment and psychosocial job quality: is a poor job better than no job at all? *Psychological Medicine, 43*(8), 1763-1772.

Buys, N., Matthews, L. R., & Randall, C. (2015). Contemporary vocational rehabilitation in Australia. *Disability and Rehabilitation, 37*(9), 820-824.

Byrnes, C., & Lawn, S. (2013). Disability employment services in Australia: a brief primer. *The Australian Journal of Rehabilitation Counselling, 19*(1), 46-56.

Callahan, M., & Mank, D. (1998). *Choice and control of employment for people with disabilities*. Retrieved from http://www.marcgold.com/publications

Canadian Mental Health Association. (2015). What's the difference between mental health and mental illness. *Here to help. Mental health and substance use information you can trust. .* Retrieved from https://www.heretohelp.bc.ca/q-and-a/whats-the-difference-between-mental-health-and-mental-illness

Canivet, C., Bodin, T., Emmelin, M., Toivanen, S., Moghaddassi, M., & Östergren, P.-O. (2016). Precarious employment is a risk factor for poor mental health in young individuals in Sweden: a cohort study with multiple follow-ups. *BMC Public Health, 16*(1), 687.

Carey, G., Dickinson, H., Malbon, E., & Reeders, D. (2018). The vexed question of market stewardship in the public sector: examining equity and the social contract through the Australian national disability insurance scheme. *Social Policy & Administration, 52*(1), 387-407.

Carroll, A., Davar, B., Eaton, J., Catherine, R., Cambri, J., Devine, A., & Vaughan, C. (2016). Promoting the rights of people with psychosocial disability in development research and programming. *Development Bulletin,* 77.

Cass, B. (1988). *Social Security Review issues paper no. 4—income support for the unemployed in Australia: towards a more active system.* Canberra Australian Government Publishing Service.

Caswell, D., Larsen, J. E., & Sieling-Monas, S. M. (2015). Cash Benefit Recipients—Vulnerable or Villains? In T. T. Bengtsson, M. Frederiksen, & J. E. Larsen (Eds.), *The Danish Welfare State: A Sociological Investigation* (pp. 217-231). New York: Palgrave Macmillan US.

Chang, L., Douglas, N., Scanlan, J. N., & Still, M. (2016). Implementation of the enhanced intersectoral links approach to support increased employment outcomes for consumers of a large metropolitan mental health service. *British Journal of Occupational Therapy, 79*(11), 643-650.

Chesterman, J. (2015). Modernising Adult Protection in an Age of Choice. *Australian Journal of Public Administration, 73*(4), 517-524.

Children with Disabilities Australia. (2015). *Post-School Transition. The experiences of students with disabilities* Retrieved from https://www.cyda.org.au/post-school-transition

Clandinin, D. J. (2006). Narrative inquiry: A methodology for studying lived experience. *Research Studies in Music Education, 27*(1), 44-54.

Clarke, J., Smith, N., & Vidler, E. (2005). Consumerism and the reform of public services: inequalities and instabilities. *Social Policy Review, 17*, 167-182.

Clarke, J., Smith, N., & Vidler, E. (2006). The indeterminacy of choice: political, policy and organisational implications. *Social Policy and Society, 5*(3), 327-336.

Collie, A., Sheehan, L., & McAllister, A. (2019). *The Health of Disability Support Pension and Newstart Allowance Recipients: Analysis of National Health Survey Data* Retrieved from https://apo.org.au/sites/default/files/resource-files/2019/09/apo-nid257481-1384961.pdf

Collyer, F. M., Willis, K. F., Franklin, M., Harley, K., & Short, S. D. (2015). Healthcare choice: Bourdieu's capital, habitus and field. *Current Sociology, 63*(5), 685-699.

Considine, M., Nguyen, P., & O'Sullivan, S. (2018). New public management and the rule of economic incentives: Australian welfare-to-work from job market signalling perspective. *Public Management Review, 20*(8), 1186-1204.

Considine, M., O'Sullivan, S., & Nguyen, P. (2014). New public management and welfare-to-work in Australia: Comparing the reform agendas of the ALP and the Coalition. *Australian Journal of Political Science, 49*(3), 469-485.

Cook, L. (2019). Mental health in Australia: a quick guide. *Parlimentary Library. Information. Analysis. Advice.* Retrieved from https://parlinfo.aph.gov.au/parlInfo/download/library/prspub/6497249/upload_binary/6497249.pdf

Corbière, M., Brouwers, E., Lanctôt, N., & van Weeghel, J. (2014). Employment specialist competencies for supported employment programs. *Journal of Occupational Rehabilitation, 24*(3), 484-497.

Cotton, R. (2019). *How People with Mental Illness in Disability Employment Services are Predisposed to Failure. Discussion Paper*. Retrieved from https://www.pc.gov.au/__data/assets/pdf_file/0018/249003/sub611-mental-health-attachment.pdf:

Council of Australian Governments. (2011). *National Disability Strategy 2010-2020*. (978-1-921647-39-0). Canberra.

Council of Australian Governments (COAG). (2017). *The Fifth National Mental Health and Suicide Prevention Plan.* Canberra: Commonwealth of Australia.

Craig, T., Shepherd, Rinaldi, M., Smith, J., Carr, S., Preston, F., & Singh, S. (2014). Vocational rehabilitation in early psychosis: cluster randomised trial. *The British Journal of Psychiatry, 205*(2), 145-150.

Creswell, J. W. (2011). Controversies in mixed methods research. In N. K. Densin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (Vol. 4, pp. 269-284). California: SAGE.

Crowther, E., & Collister, L. (2014). NDIS: Risks to vision, mission, and the way we work. *New Paradigm: The Australian Journal on Psychosocial Rehabilitation*, 23-26.

Crozier, M., & Muenchberger, H. (2013). 'It's your problem, not mine': does competence have anything to do with desire and aspiration to self-direct? *Australian Health Review, 37*(5), 621-623.

Cuddeford, J., Duncan, D., Howe, T., & Glen, F. (2008). *Life Opportunities Survey. Development findings.* Retrieved from https://webarchive.nationalarchives.gov.uk/20160129144815/http://www.ons.gov.uk/ons/rel/los/life-opportunities-survey/life-opportunities-survey/index.html

Cummins, R., Eckersley, R., Pallant, R., Van Vugt, J., & Misajon, R. (2003). Developing a National Index of Subjective Wellbeing: The Australian Unity Wellbeing Index. *Social Indicators Research, 64*(2), 159.

Cummins, R., & Lau, A. (2005). Personal Wellbeing Index. The International Wellbeing Group. Manual. Melbourne: Australian Centre on Quality of Life, Deakin University.

Dan, S., & Andrews, R. (2016). Market-type mechanisms and public service equity: A review of experiences in European public services. *Public Organization Review, 16*(3), 301-317.

Daniels, D. (2010). *Social Security Payments for the Aged, People with Disabilities and Carers 1909 to 2010.* Department of the Parliamentary Library.

Danneris, S., & Caswell, D. (2019). Exploring the ingredients of success: studying trajectories of the vulnerable unemployed who have entered work or education in Denmark. *Social Policy and Society*, 1-15.

Davidson, L., & Chan, K. K. (2014). Common factors: evidence-based practice and recovery. *Psychiatric Services, 65*(5), 675-677.

Dawson, S., & Muller, J. (2019). *Individual Placement and Support (IPS): A program for fostering hope, personal recovery and inclusive workplaces.* Paper presented at the TheMHS Building health communities. Stories of Resilience and Hope Conference, Brisbane.

Deegan, P. E. (2000). Spirit breaking: When the helping professions hurt. *The Humanistic Psychologist, 28*(1-3), 194-209.

Deloitte Access Economics. (2011). *The economic benefits of increasing employment for people with disability*. Retrieved from https://www.and.org.au/data/Conference/DAE_Report_8May.pdf

Deloitte Access Economics. (2018). *Analysis of the impact of raising benefit rates. Commissioned by the Australian Council of Social Service*. Retrieved from https://www.acoss.org.au/report/analysis-of-the-impact-of-raising-benefit-rates/

Denhov, A., & Topor, A. (2012). The components of helping relationships with professionals in psychiatry: Users' perspective. *International Journal of Social Psychiatry, 58*(4), 417-424.

Department of Education Employment and Workplace Relations. (2014). *Evaluation of Disability Employment Services 2010-2013 Final Report.* Retrieved from https://d3n8a8pro7vhmx.cloudfront.net/wecanwork/pages/38/attachments/original/1436236024/DES_Evaluation.pdf?1436236024.

Department of Employment Skills Small and Family Business. (2019). Labour Market Information Portal. Employment Region Data. Retrieved from http://lmip.gov.au/default.aspx?LMIP/Downloads/EmploymentRegion

Department of Social Services. (2013). *Characteristics of Disability Support Pension Recipients*. Canberra: Department of Social Services.

Department of Social Services. (2015a). *National Disability Employment Framework - Consultation Report September 2015*. Canberra: Department of Social Services.
Department of Social Services. (2015b). *National Disability Employment Framework Discussion Paper November 2015.* Canberra: Department of Social Services.
Department of Social Services. (2015c). *National Disability Employment Framework Issues Paper.* Retrieved from https://engage.dss.gov.au/wp-content/uploads/2015/05/issues_paper.pdf
Department of Social Services. (2016a). *Community Mental Health Individual Placement and Support Trial Operational Guidelines.* Canberra: Department of Social Services.
Department of Social Services. (2016b). *New Disability Employment Services from 2018 Discussion Paper.* Canberra: Department of Social Services.
Department of Social Services. (2017a). *Disability Employment Services Reform 2018 Industry Information Paper*. Retrieved from Canberra: https://engage.dss.gov.au/disability-employment-services-reform-2018-industry-information-paper/disability-employment-services-reform-2018-industry-information-paper-sheets/
Department of Social Services. (2017b). *Portfolio Budget Statements 2017-18 Budget Related Paper No. 1.15A*. Retrieved from https://www.dss.gov.au/about-the-department/publications-articles/corporate-publications/budget-and-additional-estimates-statements/budget-2017/portfolio-budget-statements-2017-18-budget-related-paper-no-115a
Department of Social Services. (2018a). *Disability Employment Services Grant Agreement Effective 1 July 2018.* Canberra: Australian Government.
Department of Social Services. (2018b). Government announces improved NDIS mental health support [Press release]. Retrieved from https://ministers.dss.gov.au/media-releases/3691
Department of Social Services. (2018c). *The Next Frontier in Open Employment* Paper presented at the National Disability Services Disability at Work 2018 Conference, Sydney.
Department of Social Services. (2019a). *Community Mental Health. Individual Placement and Support Trial Operational Guidelines*. Retrieved from https://www.dss.gov.au/sites/default/files/documents/12_2019/ips-trial-operational-guidelines-november-2019-d19-124024.pdf
Department of Social Services. (2019b). DES Monthly Report June 2019. Retrieved from http://lmip.gov.au/default.aspx?LMIP/Downloads/DisabilityEmploymentServicesData/MonthlyData
Department of Social Services. (2019c). *Disability Employment Services*. Paper presented at the Disability Employment Australia's National Leaders Forum, Canberra.
Department of Social Services. (2019d). DSS Payment Demographic Data. Retrieved from https://data.gov.au/dataset/ds-dga-cff2ae8a-55e4-47db-a66d-e177fe0ac6a0/details?q=newstart%20allowance
Department of Social Services. (2019e). *NDIS Participant Employment Taskforce Terms of Reference*. Canberra.
Department of Social Services. (2020). Labour Market Information Portal, DES Monthly Data Retrieved from http://lmip.gov.au/default.aspx?LMIP/Downloads/DisabilityEmploymentServicesData/MonthlyData
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and CBM. (2012). *A human rights based approach to disability in development. Entry points for development organisations.* Retrieved from https://reliefweb.int/sites/reliefweb.int/files/resources/A_human_rights-based_approach_to_disability_in_development.pdf
Devine, A., Dickinson, H., Brophy, L., Kavanagh, A., & Vaughan, C. (2019). 'I don't think they trust the choices I will make.' – Narrative analysis of choice and control for people with psychosocial disability within reform of the Australian Disability Employment Services program. *Public Management Review*. doi:DOI: 10.1080/14719037.2019.1648700

Dimov, S., Milner, A., Devine, A., LaMontagne, A., Bentley, R., Vaughan, C., . . . Kavanagh, A. (Under review). The Improving Disability Employment Study (IDES): Promoting evidence on gaining and maintaining employment for Australians with disabilities *Journal of Vocational Rehabilitation*.

Doroud, N., Fossey, E., & Fortune, T. (2015). Recovery as an occupational journey: A scoping review exploring the links between occupational engagement and recovery for people with enduring mental health issues. *Australian Occupational Therapy Journal, 62*(6), 378-392.

Doyle, L., Brady, A.-M., & Byrne, G. (2009). An overview of mixed methods research. *Journal of Research in Nursing, 14*(2), 175-185.

Drake, R. E., & Whitley, R. (2014). Recovery and severe mental illness: description and analysis. *The Canadian Journal of Psychiatry, 59*(5), 236-242.

Drew, N., Funk, M., Tang, S., Lamichhane, J., Chávez, E., Katontoka, S., . . . Saraceno, B. (2011). Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. *The Lancet, 378*(9803), 1664-1675.

Dunn, E. C., Wewiorski, N. J., & Rogers, E. S. (2008). The meaning and importance of employment to people in recovery from serious mental illness: results of a qualitative study. *Psychiatric Rehabilitation Journal, 32*(1), 59.

Eklund, M. (2007). Perceived control: How is it related to daily occupation in patients with mental illness living in the community? *American Journal of Occupational Therapy, 61*(5), 535-542.

Ey, C. (2012). *Social security payments for the unemployed, the sick and those in special circumstances, 1942 to 2012: a chronology*. Retrieved from https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BN/2012-2013/SSPaymentsUnemployment.

Ezzy, D. (2000). Fate and agency in job loss narratives. *Qualitative Sociology, 23*(1), 121-134.

Fankhaeser, S., Sehlleier, F., & Stern, N. (2008). Climate change, innovation and jobs. *Climate policy, 8*(4), 421-429.

Farkas, M., Gagne, C., Anthony, W., & Chamberlin, J. (2005). Implementing recovery oriented evidence based programs: Identifying the critical dimensions. *Community Mental Health Journal, 41*(2), 141-158.

Federation of Ethnic Communities' Councils of Australia, & Inc, N. E. D. A. (2015). Joint FECCA & NEDA Submission to the Australian Human Rights Commission's 'Willing to Work' Inquiry: Employment Discrimination Against Older Australians and Australians with Disability. Retrieved from https://engage.dss.gov.au/disability-employment-services-reform/

Fisher, M., & Baum, F. (2010). The social determinants of mental health: implications for research and health promotion. *Australian & New Zealand Journal of Psychiatry, 44*(12), 1057-1063.

Frank, A. W. (2012). *Practicing dialogical narrative analysis In: Varieties of narrative analysis*. Thousand Oaks, CA: SAGE Publications.

Frasquilho, D., Matos, M. G., Salonna, F., Guerreiro, D., Storti, C. C., Gaspar, T., & Caldas-de-Almeida, J. M. (2015). Mental health outcomes in times of economic recession: a systematic literature review. *BMC Public Health, 16*(1), 115.

Friedli, L., & World Health Organization. (2009). *Mental health, resilience and inequalities*. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf

Gergen, K. J., & Gergen, M. M. (1988). Narrative and the self as relationship. In L. Berkowitz (Ed.), *Advances in Experimental Social Psychology* (Vol. 21, pp. 17-56). New York: Academic Press.

Giddings, L. S., & Grant, B. M. (2006). Mixed methods research for the novice researcher. *Contemporary nurse, 23*(1), 3-11.

Gilchrist, D., Knight, P., Edmonds, C., & Emery, T. (2019). *Six Years and Counting: The NDIS and the Australian Disability Services System. A White Paper*. Retrieved from https://www.uwa.edu.au/projects/six-years-and-counting-the-ndis-and-the-australian-disability-services-system:

Giuliani, G. (2015). *The Impact of the'Worker-Client'Relationship in Achieving Employment Outcomes in Contracted Employment Programmes.* (Doctor of Social Work), Victoria University.
Gladman, B., & Waghorn, G. (2016). Personal experiences of people with serious mental illness when seeking, obtaining and maintaining competitive employment in Queensland, Australia. *Work, 53*(4), 835-843.
Glendinning, C. (2008). Increasing choice and control for older and disabled people: a critical review of new developments in England. *Social Policy & Administration, 42*(5), 451-469.
Goggin, G., & Newell, C. (2005). *Disability in Australia: Exposing a social apartheid*: UNSW Press.
Gottfredson, G. D., & Holland, J. L. (1990). A longitudinal test of the influence of congruence: Job satisfaction, competency utilization, and counterproductive behavior. *Journal of Counseling Psychology, 37*(4), 389.
Gray, D. E. (2001). Accommodation, resistance and transcendence: Three narratives of autism. *Social Science & Medicine, 53*(9), 1247-1257.
Gringold, S. (2019). Why the staffing cap still matters post-election. Retrieved from https://www.disabilityservicesconsulting.com.au/resources/why-staffing-caps-matter
Halcomb, E. (2019). Mixed methods research. *Journal of Advanced Nursing, 75*(3), 499-501.
Hand, C., & Tryssenaar, J. (2006). Small business employers' views on hiring individuals with mental illness. *Psychiatric Rehabilitation Journal, 29*(3), 166.
Handicapped Programs Review. (1985). *New directions: Report of the Handicapped Programs Review.* Canberra: Australian Government Publishing Service.
Harpur, P. (2012). Embracing the new disability rights paradigm: the importance of the Convention on the Rights of Persons with Disabilities. *Disability & Society, 27*(1), 1-14.
Harris, L. M., Matthews, L. R., Penrose-Wall, J., Alam, A., & Jaworski, A. (2014). Perspectives on barriers to employment for job seekers with mental illness and additional substance-use problems. *Health & Social Care in the Community, 22*(1), 67-77.
Harumová, A. (2016). Inclusive Labor Markets as a Solution of Long Term Unemployment in Slovakia. *Mediterranean Journal of Social Sciences, 7*(2), 194.
Harvey, C., Brophy, L., Parsons, S., Moeller-Saxone, K., Grigg, M., & Siskind, D. (2016). People living with psychosocial disability: Rehabilitation and recovery-informed service provision within the second Australian national survey of psychosis. *Australian & New Zealand Journal of Psychiatry, 50*(6), 534-547.
Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health, 103*(5), 813-821.
Hayes-Brown, P. (2019). Lived experience is important but it shouldn't be a deal breaker *The Sydney Morning Herald.* Sydney: Nine Entertainment Co.
Hayes, L., Brophy, L., Harvey, C., Tellez, J. J., Herrman, H., & Killackey, E. (2018). Enabling choice, recovery and participation: evidence-based early intervention support for psychosocial disability in the National Disability Insurance Scheme. *Australasian Psychiatry, 26*(6), 578-585.
Herrman, H., Saxena, S., & Moodie, R. (2005). *Promoting mental health: concepts, emerging evidence, practice: a report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne*. Geneva: World Health Organization.
Herscovitch, A., & Stanton, D. (2008). History of social security in Australia. *Family Matters*(80), 51.
Holland, J., Thomson, R., & Henderson, S. (2006). *Qualitative longitudinal research: A discussion paper* (1874418624). Retrieved from http://www1.lsbu.ac.uk/ahs/downloads/families/familieswp21.pdf
Hood, C. (1991). A public management for all seasons? *Public Administration, 69*(1), 3-19.
Hood, C. (1995). The “New Public Management” in the 1980s: variations on a theme. *Accounting, Organizations and Society, 20*(2-3), 93-109.

Howard, C. (2012). The contradictions of individualized activation policy: Explaining the rise and demise of One to One Service in Australia. *Critical Social Policy, 32*(4), 655-676.
Howe, K. R. (2004). A critique of experimentalism. *Qualitative Inquiry, 10*(1), 42-61.
Jacobs, K., Hulse, K., Stone, W., & Wiesel, I. (2016). *Individualised housing assistance: findings and policy options*. Retrieved from http://www.ahuri.edu.au/research/final-reports/269,
Jahoda, M. (1982). *Employment and unemployment: A social-psychological analysis* (Vol. 1). London: Cambridge University Press.
Jenkinson, C., & Layte, R. (1997). Development and testing of the UK SF-12. *Journal of Health Services Research & Policy, 2*(1), 14-18.
Jenkinson, J. (1993). Who shall decide? The relevance of theory and research to decision-making by people with an intellectual disability. *Disability, Handicap & Society, 8*(4), 361-375.
Jilke, S. (2015). Choice and equality: are vulnerable citizens worse off after liberalization reforms? *Public Administration, 93*(1), 68-85.
Joint Standing Committee on the National Disability Insurance Scheme. (2017). *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*. Canberra.
Kane, R. (2019). *DES, NDIS, disability policy and current issues.* Paper presented at the Disability Employment Australia Leaders Forum, Canberra.
Kavanagh, A., Aitken, Z., Emerson, E., Sahabandu, S., Milner, A., Bentley, R., . . . Studdert, D. (2016). Inequalities in socio-economic characteristics and health and wellbeing of men with and without disabilities: A cross-sectional analysis of the baseline wave of the Australian Longitudinal Study on Male Health. *BMC Public Health, 16*(3), 23.
Kavanagh, A., Krnjacki, L., Aitken, Z., LaMontagne, A., Beer, A., Baker, E., & Bentley, R. (2015). Intersections between disability, type of impairment, gender and socio-economic disadvantage in a nationally representative sample of 33,101 working-aged Australians. *Disability and Health Journal, 8*(2), 191-199.
Kayess, R., & French, P. (2008). Out of darkness into light? Introducing the Convention on the Rights of Persons with Disabilities. *Human Rights Law Review, 8*(1), 1-34.
Keogh, M., & Down, E. (2014). *What are the enablers and barriers to implementation of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) in the Indo-Pacific?* CBM-Nossal Institute Partnership for Disability Inclusive Development
King, J., & Waghorn, G. (2018). How Higher Performing Employment Specialists Engage and Support Job-seekers with Psychiatric Disabilities. *Journal of Rehabilitation, 84*(2), 48-56.
King, R., Waghorn, G., Lloyd, C., McLeod, P., McMah, T., & Leong, C. (2006). Enhancing employment services for people with severe mental illness: the challenge of the Australian service environment. *Australian and New Zealand Journal of Psychiatry, 40*(5), 471-477.
Kirby, P. (1985). *Report of the Committee of Inquiry into Labour Market Programs (Kirby Report)*. Canberra Australian Government Publishing Service.
Knight, F., Kokanović, R., Ridge, D., Brophy, L., Hill, N., Johnston-Ataata, K., & Herrman, H. (2018). Supported Decision-Making: The Expectations Held by People With Experience of Mental Illness. *Qualitative Health Research, 28*(6), 1002-1015.
LaMontagne, A., Krnjacki, L., Milner, A., Butterworth, P., & Kavanagh, A. (2016). Psychosocial job quality in a national sample of working Australians: a comparison of persons working with versus without disability. *SSM-population health, 2*, 175-181.
LaMontagne, A., Milner, A., Krnjacki, L., Kavanagh, A., Blakely, T., & Bentley, R. (2014). Employment arrangements and mental health in a cohort of working Australians: are transitions from permanent to temporary employment associated with changes in mental health? *American Journal of Epidemiology, 179*(12), 1467-1476.
Lantz, S., & Marston, G. (2012). Policy, citizenship and governance: the case of disability and employment policy in Australia. *Disability & Society, 27*(6), 853-867.

Lawrence, D., Hancock, K. J., & Kisely, S. (2013). The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. *British Medical Journal, 346*(7909), 13.

Lawson, J., Pawson, H., Troy, L., van den Nouwelant, R., & Hamilton, C. (2018). Social housing as infrastructure: an investment pathway: Australian Housing and Urban Research Institute.

Le Boutillier, C., Leamy, M., Bird, V. J., Davidson, L., Williams, J., & Slade, M. (2011). What does recovery mean in practice? A qualitative analysis of international recovery-oriented practice guidance. *Psychiatric Services, 62*(12), 1470-1476.

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry, 199*(6), 445-452.

Li, J., Brown, L., H.N, L., Miranti, R., & Vidyattama. (2019). *Inequalities In Standards of Living: Evidence for Improved Income Support for People with Disability*. Retrieved from https://www.afdo.org.au/dsp-reports/

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*(1), 363-385.

Llewellyn-Beardsley, J., Rennick-Egglestone, S., Callard, F., Crawford, P., Farkas, M., Hui, A., . . . Slade, M. (2019). Characteristics of mental health recovery narratives: Systematic review and narrative synthesis. *PloS one, 14*(3), e0214678. doi:10.1371/journal.pone.0214678

Lloyd, C., Tse, S., Waghorn, G., & Hennessy, N. (2008). Motivational interviewing in vocational rehabilitation for people living with mental ill health. *International Journal of Therapy and Rehabilitation, 15*(12), 572-579.

Lockett, H., Waghorn, G., & Kydd, R. (2018). A framework for improving the effectiveness of evidence-based practices in vocational rehabilitation. *Journal of Vocational Rehabilitation, 49*(1), 15-31.

Lund, C., Breen, A., Flisher, A. J., Kakuma, R., Corrigall, J., Joska, J. A., . . . Patel, V. (2010). Poverty and common mental disorders in low and middle income countries: A systematic review. *Social Science & Medicine, 71*(3), 517-528.

Lund, C., Brooke-Sumner, C., Baingana, F., Baron, E. C., Breuer, E., Chandra, P., . . . Kieling, C. (2018). Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. *The Lancet Psychiatry, 5*(4), 357-369.

Lustig, D. (2014). Causal relationship between chronic poverty and disability. In D. R. Strauser (Ed.), *Career development, employment, and disability in rehabilitation: From theory to practice*. New York: Springer Publishing Company

Maker, Y. (2017). *Beyond breadwinners, caregivers, martyrs and burdens: a new framework for managing competing claims in care and support policy.* (Doctorate in Philosophy), University of Melbourne.

Marston, G., Cowling, S., & Bielefeld, S. (2016). Tensions and contradictions in Australian social policy reform: compulsory Income Management and the National Disability Insurance Scheme. *Australian Journal of Social Issues, 51*(4), 399-417.

Matthews, L. R., Harris, L. M., Jaworski, A., Alam, A., & Bozdag, G. (2014). Function, health and psychosocial needs in job-seekers with anxiety, mood, and psychotic disorders who access disability employment services. *Work, 49*(2), 271-279.

McClelland, A., & Smyth, P. (2014). *Social policy in Australia: Understanding for action* (3 ed.). Melbourne: Oxford University Press.

McClure, P., Sinclair, S., & Aird, W. (2015). *A New System for Better Employment and Social Outcomes*. Retrieved from https://www.dss.gov.au/sites/default/files/documents/02_2015/dss001_14_final_report_access_2.pdf

McDonald, C., & Marston, G. (2006). Room to move? Professional discretion at the frontline of welfare-to-work. *Australian Journal of Social Issues, 41*(2), 171-182.

McDonald, C., & Marston, G. (2008). Re-visiting the quasi-market in employment services: Australia's job network. *Asia Pacific Journal of Public Administration, 30*(2), 101-117.
McDowell, C. (2018). *Moving clients forward: a grounded theory study of employment specialists' views and practices.* (Doctor of Philosophy), La Trobe University, Melbourne.
McManus, S., & Lord, C. (2012). Circumstances of people with sight loss-secondary analysis of Understanding Society and the Life Opportunities Survey. *Natcen report for RNIB*.
Mellifont, D. (2017). DESperately Seeking Service: A narrative review informing a disability employment services reform framework for Australians with mental illness. *Work, 58*(4), 463-472.
Mental Health Australia, & KPMG. (2018). *Investing to Save: The economic benefits for Australia of investment in mental health reform.* Retrieved from Canberra:
Mental Health Commission of New Zealand. (1998). *Blueprint for mental health services in New Zealand: How things need to be*. Wellington: Mental Health Commission.
Mental Health Standing Committee. (2010). *National standards for mental health services 2010*. Canberra: Commonwealth of Australia.
Michael, L. (2019a). Coalition wants to get more people with disability working in the public service. Retrieved from https://probonoaustralia.com.au/news/2019/05/coalition-wants-to-get-more-people-with-disability-working-in-the-public-service/
Michael, L. (2019b). Minister for the NDIS included in Morrison's new-look cabinet. Retrieved from https://probonoaustralia.com.au/news/2019/05/minister-for-the-ndis-included-in-morrisons-new-look-cabinet
Michael, L. (2019c). Morrison vows to prioritise NDIS following election win. Retrieved from https://probonoaustralia.com.au/news/2019/05/morrison-vows-to-prioritise-ndis-following-election-win/
Milner, A., LaMontagne, A., Aitken, Z., Bentley, R., & Kavanagh, A. M. (2014). Employment status and mental health among persons with and without a disability: evidence from an Australian cohort study. *Journal of Epidemiology and Community Health*, jech-2014-204147.
Milner, A., Shields, M., King, T., Aitken, Z., LaMontagne, A., & Kavanagh, A. (2019). Disabling working environments and mental health: A commentary. *Disability and Health Journal, 12*(4), 537-541.
Mithen, J., Aitken, Z., Ziersch, A., & Kavanagh, A. M. (2015). Inequalities in social capital and health between people with and without disabilities. *Social Science & Medicine, 126*, 26-35.
Modini, M., Joyce, S., Mykletun, A., Christensen, H., Bryant, R. A., Mitchell, P. B., & Harvey, S. B. (2016). The mental health benefits of employment: Results of a systematic meta-review. *Australasian Psychiatry, 24*(4), 331-336.
Morgan, V. A., Waterreus, A., Jablensky, A., Mackinnon, A., McGrath, J. J., Carr, V., . . . Harvey, C. (2012). People living with psychotic illness in 2010: the second Australian national survey of psychosis. *Australian & New Zealand Journal of Psychiatry, 46*(8), 735-752.
Morris, A., Waghorn, G., Robson, E., Moore, L., & Edwards, E. (2014). Implementation of evidence-based supported employment in regional Australia. *Psychiatric Rehabilitation Journal, 37*(2), 144.
Mueser, K. T., Drake, R. E., & Bond, G. R. (2016). Recent advances in supported employment for people with serious mental illness. *Current Opinion in Psychiatry, 29*(3), 196-201.
Murfitt, K., Crosbie, J., Zammit, J., & Williams, G. (2018). Employer engagement in disability employment: A missing link for small to medium organizations–a review of the literature. *Journal of Vocational Rehabilitation, 48*(3), 417-431.
Murfitt, K., Zammit, J., Bryant, R., Strachan, V., & Williams, G. (2017). *Diversity Field Officer Service Pilot Project Evaluation*. Retrieved from
National Disability Insurance Agency. (2014). Mainstream interface: Employment. Supports the NDIS will fund in relation to employment: National Disability Insurance Agency.

National Disability Insurance Agency. (2018). COAG Disability Reform Council Quarterly Report 31 December 2018 [Press release]
National Disability Insurance Agency. (2019a). *COAG Disability Reform Council Quarterly Report 30 September 2019*. Retrieved from: https://www.ndis.gov.au/about-us/publications/quarterly-reports
National Disability Insurance Agency. (2019b). *COAG Disability Reform Council Quartley Performance Report Q3 2018/2019.* Retrieved from https://www.ndis.gov.au/about-us/publications/quarterly-reports:
National Disability Insurance Agency. (2019c). *NDIS Participant Employment Taskforce*. Paper presented at the Disability Employment Australia Leaders Forum, Canberra.
National Disability Insurance Agency. (2019d). *NDIS Participants Employment Strategy*.
National Disability Insurance Agency. (2019e). *NDIS Price Guide 2019-2020*. Retrieved from https://www.ndis.gov.au/participants/using-your-plan/managing-your-plan/understanding-price-guide
National Disability Insurance Agency. (2020). *COAG Disability Reform Council Quarterly Report 31 December 2019*. Retrieved from https://www.ndis.gov.au/about-us/publications/quarterly-reports
National Disability Services. (2016). *Response to the Discussion Paper on new Disability Employment Services from 2018*. Retrieved from https://engage.dss.gov.au/category/des_reform_nov16/
National Mental Health Consumer & Carer Forum (NMHCCF). (2011). *Unravelling Psychosocial Disability, A Position Statement by the National Mental Health Consumer & Carer Forum on Psychosocial Disability Associated with Mental Health Conditions*. Retrieved from https://nmhccf.org.au/sites/default/files/docs/nmhccf_psychosocial_disability_booklet_web_version_27oct11.pdf
Needham, C., & Dickinson, H. (2018). 'Any one of us could be among that number': Comparing the Policy Narratives for Individualized Disability Funding in Australia and England. *Social Policy & Administration, 52*(3), 731-749.
Nevile, A. (2008). Human rights, power and welfare conditionality. *Australian Journal of Human Rights, 14*(1), 1-20.
Nevile, A. (2012, August 27-29). *Reframing rights as obligations: Implications of 'responsible citizenship'.* Paper presented at the International Research Workshop - The Politics of Citizenship in the Era of Human Rights, Sydney.
Nevile, A. (2016). *Submission in response to New Disability Employment Services 2018 Discussion Paper*. Retrieved from https://engage.dss.gov.au/disability-employment-services-reform/
Nevile, A., & Lohmann, R. (2011). *"It is like they just don't trust us": Balancing trust and control in the provision of disability employment services*. Retrieved from https://crawford.anu.edu.au/sparc/pdf/2011/20110621_final_report.pdf
Nguyen, T., & Velayutham, S. (2018). Street-level discretion, emotional labour and welfare frontline staff at the Australian employment service providers. *Australian Journal of Social Issues, 53(2)*(2), 158-172.
Nieuwenhuijsen, K., Schene, A. H., Stronks, K., Snijder, M. B., Frings-Dresen, M. H., & Sluiter, J. K. (2015). Do unfavourable working conditions explain mental health inequalities between ethnic groups?: Cross-sectional data of the HELIUS study. *BMC Public Health, 15*(1), 805.
Noel, V. A., Bond, G. R., Drake, R. E., Becker, D. R., McHugo, G. J., Swanson, S. J., . . . Greene, M. A. (2017). Barriers and facilitators to sustainment of an evidence-based supported employment program. *Administration and Policy in Mental Health and Mental Health Services Research, 44*(3), 331-338.
Nussbaum, M. C. (2011). *Creating capabilities. The Human Development Approach* Massachusetts: Harvard University Press.

O'Brien, J., & Dempsey, I. (2004). Comparative analysis of employment services for people with disabilities in Australia, Finland, and Sweden. *Journal of Policy and Practice in Intellectual Disabilities, 1*(3-4), 126-135.

O'Halloran, D., Farnworth, L., & Thomacos, N. (2019). Australian employment services: Help or hindrance in the achievement of mutual obligation? *Australian Journal of Social Issues*.

Olney, S. (2016). *False economy: New Public Management and the welfare-to-work market in Australia.* (Doctorate of Philosophy), University of Melbourne.

Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. A. (2007). An analysis of the definitions and elements of recovery: a review of the literature. *Psychiatric Rehabilitation Journal, 31*(1), 9.

Organisation for Economic Co-operation and Development. (2009). *Sickness, Disability and Work: Keeping on Track in the Economic Downturn*. Retrieved from http://www.oecd.org/employment/emp/42699911.pdf.

Organisation for Economic Co-operation and Development. (2017). *Connecting People with Jobs: Key Issues for Raising Labour Market Participation in Australia*. Paris: OECD Publishing.

Orygen National Centre of Excellence in Youth Mental Health. (2016). *Submission to the New Disability Employment Services from 2018: Discussion Paper*. Retrieved from https://engage.dss.gov.au/disability-employment-services-reform/

Orygen Youth Health Research Centre. (2014). *Tell them they're dreaming. Work, Education and Young People with Mental Illness in Australia*. Retrieved from https://www.orygen.org.au/Policy/Policy-Reports/Work-Education-Young-People/tell-them-theyre-dreaming-view?ext=.

Osborne, S. P. (2006). The New Public Governance? *Public Management Review, 8*(3), 377-387. doi:10.1080/14719030600853022

Paluch, T., Fossey, E., & Harvey, C. (2012). Social firms: building cross-sectoral partnerships to create employment opportunity and supportive workplaces for people with mental illness. *Work, 43*(1), 63-75.

Parent, W. (1996). Consumer choice and satisfaction in supported employment. *Journal of Vocational Rehabilitation, 6*(1), 23-30.

Parletta, V. (2015). *Evaluating evidence-based supported employment implemented within an Australian Disability Employment Service for adults with mental illness.* (Doctorate of Business Administration), University of Newcastle, Newcastle.

Parletta, V., & Waghorn, G. (2016). The financial viability of evidence-based supported employment for people with mental illnesses in a blended funding system. *Journal of Vocational Rehabilitation*(44), 227-241.

Parliament of Australia. (2017). *Budget Review 2017-2018*. Retrieved from https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview201718.

Parliament of Australia. (2018). *Disability Support Pension. Historical and Projected Trends. Report no.01/2018*. Retrieved from Canberra: https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Budget_Office/Publications/Research_reports/Disability_support_pension_Historical_and_projected_trends

Patterson, C., Moxham, L., Taylor, E., Sumskis, S., Perlman, D., Brighton, R., . . . Keough, E. (2016). Perceived control among people with severe mental illness: a comparative study. *Archives of Psychiatric Nursing, 30*(5), 563-567.

Perkins, D. J. (2008). The new employment services system. *Australian Journal of Labour Law, 21*(3), 374-382.

Perkins, D. J. (2011). *Activation and inclusion of unemployed people facing severe personal barriers.* (Doctorate of Philosophy), University of Melbourne.

Productivity Commission. (2011). *Long Term Disability Care and Support Inquiry Report*. Retrieved from https://www.pc.gov.au/inquiries/completed/disability-support/report
Productivity Commission. (2017). *National Disability Insurance Scheme (NDIS) Costs, Study Report*. Canberra: Australian Government
Productivity Commission. (2018). *Rising inequality? A stocktake of the evidence* (1740376633). Retrieved from https://www.pc.gov.au/research/completed/rising-inequality
Productivity Commission. (2019a). *Mental Health, Draft Report* Retrieved from Canberra: https://www.pc.gov.au/inquiries/current/mental-health/draft
Productivity Commission. (2019b). *Review of the National Disability Agreement*. Canberra.
Provencher, H. L., Gregg, R., Mead, S., & Mueser, K. T. (2002). The role of work in the recovery of persons with psychiatric disabilities. *Psychiatric Rehabilitation Journal, 26*(2), 132.
Purcal, C., Fisher, K. R., & Laragy, C. (2014). Analysing choice in Australian individual funding disability policies. *Australian Journal of Public Administration, 73*(1), 88-102.
Quick, J. C., Murphy, L. R., Hurrell Jr, J. J., & Orman, D. (1992). The value of work, the risk of distress, and the power of prevention. In J. C. Quick, L. R. Murphy, & J. J. Hurrell Jr (Eds.), *Stress and wellbeing at work: Assessments and interventions for occupational mental health.* Washington, DC.: American Psychological Association.
Rampton, N., Waghorn, G., De Souza, T., & Lloyd, C. (2010). Employment service provider knowledge of service user assistance needs. *American Journal of Psychiatric Rehabilitation, 13*(1), 22-39.
Ridgway, P. (2001). Restorying psychiatric disability: learning from first person recovery narratives. *Psychiatric Rehabilitation Journal, 24*(4), 335.
Riley, T., & Hawe, P. (2005). Researching practice: the methodological case for narrative inquiry. *Health Education Research, 20*(2), 226-236.
Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers*: Sage.
Ritter, E., Strauser, D. R., O'Sullivan, D., Reid, J., Khosravisnasr, S., & Cronin, T. (2013). Chapter 6 Theories of Career Development and Work Adjustment. In D. R. Strauser (Ed.), *Career development, employment, and disability in rehabilitation: From theory to practice* (pp. 97-112). New York: Springer Publishing Company
Rumpf, H.-J., Meyer, C., Hapke, U., & John, U. (2001). Screening for mental health: validity of the MHI-5 using DSM-IV Axis I psychiatric disorders as gold standard. *Psychiatry Research, 105*(3), 243-253. doi:https://doi.org/10.1016/S0165-1781(01)00329-8
Russinova, Z., Rogers, S. E., Ellison, M. L., & Lyass, A. (2011). Recovery-Promoting Professional Competencies: Perspectives of Mental Health Consumers, Consumer-Providers and Providers. *Psychiatric Rehabilitation Journal*(3), 177. doi:10.2975/34.3.2011.177.185
Saleh, M. C., & Bruyère, S. M. (2018). Leveraging Employer Practices in Global Regulatory Frameworks to Improve Employment Outcomes for People with Disabilities. *Social Inclusion, 6*(1), 18-28.
Salzer, M., & Baron, R. (2016). *Well Together. A blueprint for community inclusion: fundamental concepts, theoretical frameworks and evidence*. Retrieved from https://media.wellways.org/inline-files/Well%20Together.pdf
Scanlan, J. N., Feder, K., Ennals, P., & Hancock, N. (2019). Outcomes of an individual placement and support programme incorporating principles of the collaborative recovery model. *Australian Occupational Therapy Journal, 66*, 519-529.
Schofield, T. P., & Butterworth, P. (2018). Are Negative Community Attitudes Toward Welfare Recipients Associated With Unemployment? Evidence From an Australian Cross-Sectional Sample and Longitudinal Cohort. *Social Psychological and Personality Science, 9*(5), 503-515.
Schrank, B., Bird, V., Rudnick, A., & Slade, M. (2012). Determinants, self-management strategies and interventions for hope in people with mental disorders: systematic search and narrative review. *Social Science & Medicine, 74*(4), 554-564.

Shanks, V., Williams, J., Leamy, M., Bird, V. J., Le Boutillier, C., & Slade, M. (2013). Measures of personal recovery: a systematic review. *Psychiatric Services, 64*(10), 974-980.
Shaw, L., MacKinnon, J., McWilliam, C., & Sumsion, T. (2004). Consumer participation in the employment rehabilitation process: Contextual factors and implications for practice. *Work, 23*(3), 181-192.
Sherring, J., Robson, E., Morris, A., Frost, B., & Tirupati, S. (2010). A working reality: Evaluating enhanced intersectoral links in supported employment for people with psychiatric disabilities. *Australian Occupational Therapy Journal, 57*(4), 261-267. doi:10.1111/j.1440-1630.2009.00844.x
Silva, M., Loureiro, A., & Cardoso, G. (2016). Social determinants of mental health: a review of the evidence. *The European Journal of Psychiatry, 30*(4), 259-292.
Simonsen, M., Fabian, E., & Ethridge, G. (2013). Youth and Adults With Psychiatric Disabilities: Improving Career and Employment. In D. R. Strauser (Ed.), *Career development, employment, and disability in rehabilitation: From theory to practice* (pp. 401). New York: Springer Publishing Company.
Slade, M. (2010). Mental illness and well-being: the central importance of positive psychology and recovery approaches. *BMC Health Services Research, 10*(1), 26.
Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., . . . Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry, 13*(1), 12-20.
Slade, M., & Longden, E. (2015). *The empirical evidence about mental health and recovery: how likely, how long, what helps*. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4647297/
Smith-Merry, J., Buchanan, J., Yen, I., & Drinkwater, A. (2019). *Creating Healthy Communities for Learning: Vocational Education and Training (VET) in NSW*. Paper presented at the The Mental Health Services Conference, Building Healthy Communities. Stories of Resilience and Hope, Brisbane.
Smith-Merry, J., Buchanan, J., Yen, I., Drinkwater, A., & Smith, B. (2020). *Vocational Education and Training, Disability and Disadvantage: Final Report.* Retrieved from Centre for Disability Research and Policy, Sydney:
Smith-Merry, J., Hancock, N., Gilroy, J., Llewellyn, G., & Yen, I. (2018). *Mind the Gap: The National Disability Insurance Scheme and psychosocial disability Final Report: Stakeholder identified gaps and solutions.* Retrieved from Sydney
Souza, F. (Producer). (2019, 19 May 2019). The NDIS tension in boosting disability employment *The Mandarin*. Retrieved from https://www.themandarin.com.au/108698-the-ndis-tension-in-boosting-disability-employment/
Stafford, L., Marston, G., Chamorro-Koc, M., Beatson, A., & Drennan, J. (2017). Why one size fits all approach to transition in Disability Employment Services hinders employability of young people with physical and neurological disabilities in Australia. *Journal of Industrial Relations, 59*(5), 631-651.
StataCorp. (2017). Stata Statistical Software: Release 15. College Station: TX:StataCorp LLC.
State of Victoria. (2018). *2018-2019 Budget Strategy and Outlook*. Retrieved from https://www.dtf.vic.gov.au/2018-19-state-budget/2018-19-strategy-and-outlook
State of Victoria. (2019a). *Delivering for all Victorians. Victorian Budget 2019-2020 update.* Retrieved from https://budget.vic.gov.au/
State of Victoria. (2019b). *Royal Commission into Victoria's Mental Health System, Interim Report, Parl Paper No. 87 (2018–19)*. Retrieved from https://rcvmhs.vic.gov.au
Strauser, D. R. (2013). *Career development, employment, and disability in rehabilitation: From theory to practice*. New York: Springer Publishing Company.

Stuart, S. R., Tansey, L., & Quayle, E. (2017). What we talk about when we talk about recovery: a systematic review and best-fit framework synthesis of qualitative literature. *Journal of Mental Health, 26*(3), 291-304.

Suijkerbuijk, Y. B., Schaafsma, F. G., van Mechelen, J. C., Ojajärvi, A., Corbière, M., & Anema, J. R. (2017). Interventions for obtaining and maintaining employment in adults with severe mental illness, a network meta-analysis. *Cochrane Database of Systematic Reviews*(9). doi:10.1002/14651858.CD011867.pub2

Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: relationships in trauma-informed mental health services. *British Journal of Psychiatry Advances, 24*(5), 319-333.

Szymanski, E., Enright, M., & Hershenson, D. (2012). Chapter 8 An ecological approach to the vocational behavior and career development of people with disabilities. In R. M. Parker & J. B. Patterson (Eds.), *Rehabilitation counseling: Basics and beyond* (5th ed ed., pp. 199-258). Austin, Tex: PRO-ED.

Szymanski, E., & Hershenson, D. (2005). An ecological approach to vocational behavior and career development of people with disabilities. *Rehabilitation counseling: Basics and beyond, 4*, 225-280.

Szymanski, E., & Vancollins, J. (2003). Career development of people with disabilities: Some new and not-so-new challenges. *Australian Journal of Career Development, 12*(1), 9-16.

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: a review of the evidence. *The British Journal of Social Work, 42*(3), 443-460.

Thornicroft, G. (2013). Premature death among people with mental illness. *British Medical Journal, 346*, 7.

Trajkovic, G. (2008). *Disability Employment Reform, Social Inclusion and Mental Health*: Centre of Full Employment and Equity, University of Newcastle.

Tugade, M. M., Fredrickson, B. L., & Feldman Barrett, L. (2004). Psychological resilience and positive emotional granularity: Examining the benefits of positive emotions on coping and health. *Journal of Personality, 72*(6), 1161-1190.

UN General Assembly. (2006). *Convention on the Rights of Persons with Disabilities*. Retrieved from

United Nations Department of Economic and Social Affairs. (2019). Convention on the Rights of Persons with Disabilities. Retrieved from https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

Van de Walle, S., & Marien, S. (2017). Choice in public health services: a multilevel analysis of perceived primary care doctor choice in 22 countries. *Administration & Society, 49*(10), 1471-1493.

Victorian Equal Opportunity and Human Rights Commission. (2008). From principle to practice: implementing the human rights based approach in community organisations: VEOHRC: Melbourne.

Vigoda, E., & Cohen, A. (2003). Work congruence and excellence in human resource management: Empirical evidence from the Israeli nonprofit sector. *Review of Public Personnel Administration, 23*(3), 192-216.

Waddell, G., & Burton, A. K. (2006). *Is work good for your health and well-being?* London: The Stationery Office.

Waghorn, G., Collister, L., Killackey, E., & Sherring, J. (2007). Challenges to implementing evidence-based supported employment in Australia. *Journal of Vocational Rehabilitation*(27), 29-37.

Waghorn, G., Dias, S., Gladman, B., Harris, M., & Saha, S. (2014). A multi-site randomised controlled trial of evidence-based supported employment for adults with severe and persistent mental illness. *Australian Occupational Therapy Journal*(61). doi:10.1111/1440-1630.12148

Waghorn, G., & Hielscher, E. (2015). The availability of evidence-based practices in supported employment for Australians with severe and persistent mental illness *Australian Occupational Therapy Journal*(62), 141-144. doi:10.1111/1440-1630.12162

Warr, D., Dickinson, H., Olney, S., Hargrave, J., Karanikolas, A., Kasidis, V., . . . Wheeler, J. (2017). *Choice, Control and the NDIS: Service Users' Perspectives on having Choice and Control in the New National Disability Insurance Scheme*. Retrieved from Choice, control and the NDIS service users' perspectives on having choice and Control in the New National Disability Insurance Scheme. [DOC] from daru.org.au

Washington Group on Disability Statistics, Budapest Initiative, & United Nations Economic & Social Commission for Asia & the Pacific. (2010). *Development of Disability Measures for Surveys: The Extended Set on Functioning*. Retrieved from http://www.washingtongroup-disability.com/wp-content/uploads/2016/01/Development_of_Disability_Measures_for_Surveys_The_Extended_Set_on_Functioning.pdf

Western Australian Association for Mental Health. (2019). IPSWorks. Retrieved from http://ipsworks.waamh.org.au/news/national-ips-trial

Wilkins, R., & Wooden, M. (2013). HILDA user manual-release 12: Melbourne.

World Health Organization. (2003). *Investing in mental health*. Retrieved from https://www.who.int/mental_health/publications/investing_mental_health/en/

World Health Organization & World Bank. (2011). *World report on disability. 2011*. Retrieved from https://www.who.int/disabilities/world_report/2011/en/

World Health Organization and Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health report*. Retrieved from Geneva: https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf

World Network of Users and Survivors of Psychiatry (WNUSP). (2008). *Implementation Manual for the Convention on the Rights of Persons with Disabilities* Retrieved from http://www.wnusp.net/documents/ WNUSP_CRPD_Manual.pdf

Zafar, N., Rotenberg, M., & Rudnick, A. (2019). A systematic review of work accommodations for people with mental disorders. *Work*(Preprint), 1-15.

Ziguras, S. (2014). Social Security Policy: Doing more with Less? In A. McClelland & P. Smyth (Eds.), *Social Policy in Australia. Understanding for Action.* (Third ed., pp. 156-171). South Melbourne.: Oxford University Press.

Appendix 1. Improving Disability Employment Study (IDES) survey

CALL OUTCOMES ARE RR1

USE STANDARD CALL OUTCOMES AND RR1

PARTICIPANT INFORMATION SAMPLE FIELDS

USE STANDARD

Variable name	Variable label	Full description
FNAME	First name	Respondent's given name
SNAME	Surname	Respondent's last name
Provider_name	Provider_name	Name of provider

PROGRAMMER NOTES:

- MAKE ALL ITEMS NON-MANDATORY. DO NOT DISPLAY 'UNSURE' AND 'PREFER NOT TO SAY' IN ONLINE VERSION
- IF AN ITEM IS SKIPPED PRESENT THE QUESTION AGAIN WITH:
  - CLARIFICATION BANNER MESSAGE: "YOU SKIPPED THIS QUESTION – WERE YOU UNSURE OF YOUR RESPONSE OR DID YOU PREFER NOT TO ANSWER THIS QUESTION"
  - 'UNSURE' AND 'PREFER NOT TO SAY' RESPONSE OPTIONS DISPLAYED.
- FOR ALL MULTIPLE RESPONSE, ADD NOTE TO ONLINE: *Please select all that apply.*
- FOR CATI - ALL 'Don't know', 'Prefer not to say', 'None/not applicable' TO DISPLAY IN BRACKETS FOR CATI.
- FOR ALL READ OUT ONLY SHOW FOR CATI

INTRODUCTION AND SCREENING

WEB INFO INTRO:

This survey will have questions about your experiences of employment services, your experiences at work and your work history, including your training and education. There are also questions about your health. We want to find out what kinds of support you think you need to be able to get a job, to continue to work and what your workplace experiences have been in the past. We also want to find out what kind of work you would like to do. This study takes place at two time points over the next 12 months with an initial and follow up surveys. We estimate that each of these surveys will take about 40 minutes to complete. Each survey is voluntary and you do not need to commit to completing both surveys at this time.

This survey is being conducted by The Social Research Centre (SRC) on behalf of Melbourne University. All responses will be kept confidential. If there are any questions in the questionnaire that you do not want to answer, you do not have to answer them (if you would prefer not to answer, click on the 'next' button to proceed to the next question). If you have any questions about the survey, please email the Project Coordinator, Stefanie Dimov – stefanie.dimov@unimelb.edu.au.

IF AN SMS PARTICIPANT (RECEIVED AN SMS DURING ENROLMENT) INCLUDE LINK TO THE PLS:

If you would like further information about the study click the link to the Plain Language Statement.

***CATI WELCOME SCREEN**

PROXY=0 Hi my name is <NAME> calling on behalf of the University of Melbourne from the Social Research Centre. May I please speak with <QR NAME>?

IF QUERIED: We are just following up their request to contact them.

CATI INTRO SCRIPT

*ALL

INTRO1: We are following up on your enrolment for a study being conducted by the University of Melbourne with people who have had contact with a Disability Employment Service provider. You will have spoken with someone at [provider_name] about this recently.

You are able to complete the survey over the phone or online. Would you like to make a start on this now or can we arrange a time to call you back?

IF SPEAKING WITH NON-QR: We are just following up on a letter recently sent to <QR NAME>. Due to the strict privacy laws we operate under I am not able to discuss the nature of the call to anyone except <FNAME>. Are they available now?

1. Continue
2. Wants to complete online (SEND INVITE EMAIL)
3. Household Refusal (GO TO RR1)
4. Respondent Refusal (GO TO RR1)
5. Wants information on how details were obtained (GO TO AINFO)
6. LOTE – Identify language (no follow-up)

PRESAFE

INTERVIEWER: Are you calling a mobile number?

Yes
No (GO TO MON)

*(PRESAFE=1, CALLING A MOBILE NUMBER)

SAFE1 And could I please check whether it is safe for you to take this call at the moment? If not, we'd be happy to call back when it is more convenient for you.

1. Safe to take the call
2. Not safe to take the call (MAKE APPOINTMENT)
3. Prefer not to say (RR1)

*INTRO=5, queried how number was obtained

AINFO Your contact details were given to us by your employment service provider once you had provided consent to take part in this research.

*INTRO=2

ONLINE Thanks for that. Can I please confirm your email address so that we can send you a link to take part?

DISPLAY CURRENT EMAIL:

1. Email is correct as shown
2. Re-collect email (Specify)

VISION 6 API KEY: e6f3e625c66a94a00607ae63b4518678e6f27c6f0596649173838f9bb4509ea8

*INTRO=5 OR PLSINFO=2, wants copy of letter

RECON. Would you like a copy of the letter via email or post?

1. Confirm Email (AEML)
2. Confirm Postal Address (ALET)
3. (Prefer not to say to confirm details)

*PROGRAMMER NOTE: IF EMAIL ADDRESS IS BLANK:

AEML.Can I please have your email address?

1. Enter email address

*PROGRAMMER NOTE: IF EMAIL ADDRESS IS NOT BLANK:

RECONTACT: The email address we have for you is:

<EMAIL ADDRESS>

Is that correct?

1. Yes, Correct Email address
2. No, Collect new email address

PROGRAMMER NOTE: Display postal address from sample file.

ALET. The address I have is:

<DISPLAY ADD1, ADD2, SUBURB, PCODE AND STATE>

Is this correct?

1. Yes, all correct
2. NO – (Edit)

ALET1. < EDIT ADDRESS>

*IF INTRO=6, LOTE
LOTE.

1. Cantonese
2. Mandarin
3. Vietnamese
4. Korean
5. Hindi
6. Punjabi
7. Arabic (Middle east)
8. Turkish
9. Italian
10. Greek
11. Spanish
12. Russian
13. Other language

*IF ALOTE=13

RECORD LANGUAGE.

1. Arabic (Sudanese)
2. Bosnian
3. Croatian
4. Dari
5. Farsi
6. Filipino / Tagalog
7. Indonesian
8. Japanese
9. Khmer (Cambodian)
10. Malay
11. Macedonian
12. Persian
13. Polish
14. Serbian
15. Sinhala / Sinhalese
16. Tamil
17. Thai
18. Urdu
19. Other language (specify)
20. Language not identified / unable to establish language (GO TO LANG_UNKNOWN)

ETHICS1: Thank you. I just have a few things I need to let you know before we get started. If I come to any question you would prefer not to answer, just let me know and I'll skip over it. You can withdraw from the survey at any point, or complete the rest of the interview at another time. The interview is voluntary, and we will treat all information you provide in strict confidence as far as allowed by law. Your answers will be used for research purposes only, and only combined results from this survey will be published. No individuals who participate will be able to be identified.

1. Yes, continue
2. No, refusal (GO TO RR1)

*ALL

PLS. And before we begin, do you recall receiving an information sheet from your employment consultant about the study?

1. Yes, have PLS
2. No, did not receive PLS

*IF PLS=2, DID NOT RECEIVE PLS

PLSINFO. So that you have all the information about the project, I'd like to read you some additional information.

The study contains two interviews over a year, each interview is voluntary. The survey asks questions about your experiences of employment service providers, your work history and any training and education you may have done. There are also questions relating to your health and personal circumstances. This survey will ask about any previous work experience you may have had and what type of work you may like to do in the future.

This study has been assessed as low risk by an Ethics Committee. However, if you feel uncomfortable with any question or some of the questions trigger an emotional response, help can be provided by way of referral to other services. The researchers for the project are also available to answer any project related questions.

The findings from this research will lead to better government policy in this area and contribute to changes in employment services for people with disability. It will also help employers to know how they can support people with a disability in the workplace.

Do you have any questions before we continue?

1. Continue, no questions
2. Would like a copy of PLS before continuing
3. Refused participation.

*(ALL)

MON This interview may be recorded for quality assurance purposes – to check I am doing my job properly. Is that ok?

1. Recording allowed
2. Recording not permitted

SECTION A: DISABILITY AND WORK

*ALL

I1. To start with we'd like to ask some questions about yourself to help us analyse the results.

Firstly, what is your gender?

1. Male
2. Female
3. Other
4. Unsure *(DISPLAY ONLY FOR CATI)
5. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

I2. What is your age?

1. [Enter age] [RANGE: 18 – 99]
2. Unsure *(DISPLAY ONLY FOR CATI)
3. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

I3. How would you describe your household? For example, a couple, a couple with children, single person or something else.

1. Couple without children
2. Couple with children (includes children aged 18 years and older)
3. One parent family
4. Group household (all or most people in the household are non-related)
5. One person household
6. Other, please specify _____
7. Unsure *(DISPLAY ONLY FOR CATI)
8. Prefer not to say *(DISPLAY ONLY FOR CATI)

*(IF I3= 2, 3, 4 OR 6)

I4. How many dependent children aged 16 years or younger live in this household? (Enter "0" if not applicable)

1. Number of children in household [RANGE: 0 – 15]
2. Unsure *(DISPLAY ONLY FOR CATI)
3. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

I5. Are you of Aboriginal or Torres Strait Islander origin?

1. Yes, Aboriginal
2. Yes, Torres Strait Islander
3. Yes, both Aboriginal and Torres Strait Islander
4. No
5. Unsure *(DISPLAY ONLY FOR CATI)
6. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

I6. In which country were you born?

1. Australia
2. China
3. Greece
4. India
5. Italy
6. Lebanon
7. New Zealand
8. Turkey
9. United Kingdom / Ireland

10. Vietnam
11. Other
12. Unsure *(DISPLAY ONLY FOR CATI)
13. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF I6=11, OTHER SPECIFY

I6b. In which country were you born?

1. Fiji
2. Germany
3. Malaysia
4. Netherlands (Holland)
5. Philippines
6. Singapore
7. South Africa
8. Sri Lanka
9. United States of America
10. Other (Specify)
11. Unsure *(DISPLAY ONLY FOR CATI)
12. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

I7. Do you speak a language other than English at home?

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

I8. Would you say you can speak English:

(READ OUT)

1. Very well
2. Well
3. Not well
4. Not at all
5. Unsure *(DISPLAY ONLY FOR CATI)
6. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

I9. Thinking about reading English. Would you say you can read English:

(READ OUT)

1. Very well
2. Well
3. Not well
4. Not at all
5. Unsure *(DISPLAY ONLY FOR CATI)
6. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

AINTRO. The next questions ask about difficulties you may have doing certain activities because of a HEALTH PROBLEM.

*WASHINGTON GROUP SHORT SET A1-A6
*ALL

A1. Do you have difficulty seeing, even if wearing glasses?

1. No – no difficulty
2. Yes – some difficulty
3. Yes – a lot of difficulty
4. Cannot do at all
5. Unsure *(DISPLAY ONLY FOR CATI)
6. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

A2. Do you have difficulty hearing, even if using a hearing aid:

1. No - no difficulty
2. Yes - some difficulty
3. Yes - a lot of difficulty
4. Cannot do at all
5. Unsure *(DISPLAY ONLY FOR CATI)
6. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

A3. Do you have difficulty walking or climbing steps?

1. No - no difficulty
2. Yes - some difficulty
3. Yes - a lot of difficulty
4. Cannot do at all
5. Unsure *(DISPLAY ONLY FOR CATI)
6. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

A4. Do you have difficulty remembering or concentrating?

1. No - no difficulty
2. Yes - some difficulty
3. Yes - a lot of difficulty
4. Cannot do at all
5. Unsure *(DISPLAY ONLY FOR CATI)
6. Prefer not to say *(DISPLAY ONLY FOR CATI)

*WASHINGTON GROUP EXTENDED SET A7-A20
*ALL

A8. Do you use any equipment or receive help for getting around? This might include items such as a magnifier, orthotic device, wheelchair or hearing aid.

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*A8=1, YES ASSISTANCE REQUIRED

A9. Do you use any of the following?

Please select all that apply

*MULTI RESPONSE

(READ OUT)

1. Cane or walking stick
2. Walker or Zimmer frame
3. Crutches
4. Wheelchair or scooter
5. Artificial limb (leg/foot)
6. Hearing aid
7. White cane
8. Glasses
9. Magnifier
10. Orthotic device (to support legs, arms or spine)
11. Communication boards (e.g. a board which people use to point to and express themselves)
12. Someone else's assistance
13. Other, Please specify: [_____]

*ALL

A10. Do you have difficulty with self-care, such as washing all over or dressing?

1. No - no difficulty
2. Yes - some difficulty
3. Yes - a lot of difficulty
4. Cannot do at all
5. Unsure *(DISPLAY ONLY FOR CATI)
6. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

A11. Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood?

1. No - no difficulty
2. Yes - some difficulty
3. Yes - a lot of difficulty
4. Cannot do at all
5. Unsure *(DISPLAY ONLY FOR CATI)
6. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

A12. How often do you feel worried, nervous or anxious?

*IF CATI: If taking mood-regulating medications, please answer as to when you are using the medication. Would you say:

*IF ONLINE: *If taking mood-regulating medications, please answer as to when you are using the medication*

(READ OUT)

1. Daily
2. Weekly
3. Monthly
4. A few times a year
5. Never
6. Unsure *(DISPLAY ONLY FOR CATI)
7. Prefer not to say *(DISPLAY ONLY FOR CATI)

*A12=1,2,3 OR 4, HAVE FELT WORRIED/NERVOUS/ANXIOUS

A13. Thinking about the last time you felt worried, nervous or anxious, how would you describe the level of these feelings? Would you say:

(READ OUT)

1. A little
2. A lot
3. Somewhere in between 'A little' and 'A lot'
4. Unsure *(DISPLAY ONLY FOR CATI)
5. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

A14. How often do you feel depressed?

*IF CATI: If taking mood-regulating medications, please answer as to when you are using the medication. Would you say:

*IF ONLINE: *If taking mood-regulating medications, please answer as to when you are using the medication*

(READ OUT)

1. Daily
2. Weekly
3. Monthly
4. A few times a year
5. Never
6. Unsure *(DISPLAY ONLY FOR CATI)
7. Prefer not to say *(DISPLAY ONLY FOR CATI)

*A14=1,2,3 OR 4, FELT DEPRESSED

A15. Thinking about the last time you felt depressed, how depressed did you feel? Would you say:

(READ OUT)

1. A little
2. A lot
3. Somewhere in between 'A little' and 'A lot'
4. Unsure *(DISPLAY ONLY FOR CATI)
5. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

A16. In the past 3 months, how often did you have pain? Would you say:

(READ OUT)

1. Never
2. Some days
3. Most days
4. Every day
5. Unsure *(DISPLAY ONLY FOR CATI)
6. Prefer not to say *(DISPLAY ONLY FOR CATI)

*A16=2,3 OR 4, have pain

A17. Thinking about the last time you had pain, how much pain did you have? Would you say:

(READ OUT)

1. A little
2. A lot
3. Somewhere in between ‘A little’ and ‘A lot’
4. Unsure *(DISPLAY ONLY FOR CATI)
5. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

A18. In the past 3 months, how often did you feel very tired or exhausted? Would you say:

(READ OUT)

1. Never
2. Some days
3. Most days
4. Every day
5. Unsure *(DISPLAY ONLY FOR CATI)
6. Prefer not to say *(DISPLAY ONLY FOR CATI)

*A18=2,3 OR 4, felt exhausted

A19. Thinking about the last time you felt very tired or exhausted, how long did it last? Would you say:

(READ OUT)

1. Some of the day
2. Most of the day
3. All of the day
4. Unsure *(DISPLAY ONLY FOR CATI)
5. Prefer not to say *(DISPLAY ONLY FOR CATI)

*A18=2,3 OR 4, felt exhausted

A20. Thinking about the last time you felt this way, how would you describe the level of tiredness? Would you say:

(READ OUT)

1. A little
2. A lot
3. Somewhere in between ‘A little’ and ‘A lot’
4. Unsure *(DISPLAY ONLY FOR CATI)
5. Prefer not to say *(DISPLAY ONLY FOR CATI)

SECTION B: EMPLOYMENT SERVICES AND TRAINING

*ALL

B1. Thinking now about your employment service provider.

Did Centrelink say you had to go to an employment provider such as <INSERT PROVIDER NAME>:

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*B1=1, CENTRELINK REFERRED TO PROVIDER

B2. Did you have a choice of different employment service providers you could attend?

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF B2=1, CHOICE OF PROVIDER

B3. In choosing an employment service provider, to what extent were the following important or not important to you:

*ROTATE STATEMENTS

a) They have experience working with my kind of disability
b) They have a good reputation
c) They are easy to get to
d) I can use their computers and internet
e) They make me feel welcome
f) I will have the same consultant at each visit
g) They recognise my strengths

(RESPONSE FRAME)

1. Not at all important
2. Somewhat important
3. Extremely important
4. Unsure *(DISPLAY ONLY FOR CATI)
5. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

B4. Thinking about your current needs, what would you like your employment consultant to do:

Please select all that apply

*(ROTATE STATEMENTS)

*(MULTI RESPONSE)

(READ OUT)

1. Offer suggestions about what sort of work I might be suitable for
2. Help me find a training course
3. Help me apply for a job
4. Help me prepare for a job interview
5. Provide me with support once I have a job
6. Support me to feel confident in my ability
7. Help me participate in decisions
8. Assist me with Centrelink
9. Other, (Specify) _____
10. Unsure *(DISPLAY ONLY FOR CATI)
11. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

B14. How long ago did you start seeing <INSERT PROVIDER NAME>? If you have used this service provider previously, please answer in relation to your most recent job search.

1. Less than 3 months ago
2. At least 3 months ago but less than 6 months ago
3. At least 6 months ago but less than 12 months ago
4. 12 months ago or longer
5. Don't know *(DISPLAY ONLY FOR CATI)
6. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

B17. What personal qualities do you have that would make you a good employee?

1. [TEXT BOX]
2. Unsure *(DISPLAY ONLY FOR CATI)
3. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

B18. What skills do you have that you could bring to a job? [TEXT BOX]

1. [TEXT BOX]
2. Unsure *(DISPLAY ONLY FOR CATI)
3. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

B6. How much difficulty, if any, do you have with the following…?

*(ROTATE STATEMENTS)

a) The type of job you can do
b) The number of hours you can work
c) Finding suitable work
d) Needing time off work

(RESPONSE FRAME) (READ OUT)

1. No difficulty at all
2. Some difficulty

3. A lot of difficulty
4. Unsure *(DISPLAY ONLY FOR CATI)
5. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

B7. Thinking about your next job, would any of the following help you at work?

*(ROTATE STATEMENTS)

a) Assistance with transport to and from work (e.g. subsidised taxi scheme
b) Flexibility in hours or days or reduced work hours
c) Ability to modify duties
d) Option of working from home at times
e) A person from your work to guide and support you
f) A person from outside your work to guide and support you
g) Access to an interpreter (e.g. AUSLAN or language other than English)
h) Changes to the work area or work equipment (e.g. quiet area)
i) Building modifications (e.g. handrails or ramps, easy-to-access work area, toilets or lifts)
j) Specialist aids or equipment (e.g. headphones, Braille keyboard, computer apps, screen magnifiers, hearing supports)
k) Anything else? (please specify) *FIXED TO APPEAR LAST

(RESPONSE FRAME)

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*B7_G=1, DOES REQUIRE INTERPRETER

B7_gOth. Do you require an AUSLAN interpreter due to a hearing impairment or an interpreter for a language other than English?

1. AUSLAN interpreter due to a hearing impairment
2. Language other than English interpreter

*ALL

B8. Thinking about your own situation, including your disability and where you live, which of the following impacts the work you can do? Would you say this…

*(ROTATE STATEMENTS)

a) Lack of access to transport to get to and from work
b) Lack of jobs close to where I live
c) Family responsibilities, including looking after children
d) Caring for others such as relatives or friends with disability
e) Lack of family help or assistance
f) Lack of confidence
g) Not having the qualifications, experience or skills
h) The financial and/or Centrelink benefits I receive

(RESPONSE FRAME) (READ OUT)

1. Does not affect the work I can do
2. Somewhat affects the work I can do
3. Greatly affects the work I can do
4. Unsure *(DISPLAY ONLY FOR CATI)
5. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

B9. Thinking ahead, in 12 months' time what type of job would you like to be doing?

*[PROGRAMMER NOTE: PRESENT JOB TITLE AND DUTIES ON SAME PAGE]

B9a. **Job title** *(for example health worker, teacher, labourer, office worker, sales assistant, administrative assistant or administrative officer, cleaner or laundry worker, packer or product assembler)*

1. [LARGE TEXT BOX]
2. Unsure *(DISPLAY ONLY FOR CATI)
3. Prefer not to say *(DISPLAY ONLY FOR CATI)

B9b. **Main duties or tasks** *(for example hospital duties, classroom teaching, serving customers, carpentry, concreting, cleaning, waitressing)*

1. [LARGE TEXT BOX]
2. Unsure *(DISPLAY ONLY FOR CATI)
3. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

B10. How important are each of the following in your decision to find work…?

*(ROTATE STATEMENTS)

a) So that I can contribute to household costs like bills
b) To pay off money I owe
c) To be able to make my own decisions about spending money I have earned
d) To have time away from my caring responsibilities
e) To do something for myself
f) So that I can have a career
g) To meet other people
h) Because my family wants me to work
i) To be part of my community
j) Psychological or mental health reasons (to feel better about myself)
k) So that I do not experience negative attitudes from others about being on income support

(RESPONSE FRAME) (READ OUT)

1. Not important at all
2. Somewhat important
3. Extremely important
4. Not applicable
5. Unsure *(DISPLAY ONLY FOR CATI)
6. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

B11INTRO The following questions relate to unfair treatment or discrimination you may have experienced.

B11. In the last 12 months, do you feel that you have experienced discrimination or have been treated unfairly because of any of the following…

*(ROTATE STATEMENTS)

a) Your religion
b) Your age
c) Your own disability or health condition (FIX TO PLACEMENT 3)
d) Your gender
e) Your sexuality
f) Your race or ethnicity
g) Or some other reason, please specify _____ (FIX TO END)

(RESPONSE FRAME)

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

B11Oth. In the last 12 months, do you feel that you have experienced discrimination or have been treated unfairly because of any of the following…

1. Some other reason (specify) [TEXT BOX]

*ALL

B12. Because of your disability, have you ever experienced unfair treatment or discrimination when you:

*(ROTATE STATEMENTS)

a) Looked for a job, such as when you approached an employer directly asking for work
b) Applied for a job, such as when you talked to an employer about a position available and were discouraged from applying
c) Went to a job interview, such as being asked inappropriate questions about your disability or other personal questions

(RESPONSE FRAME)

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

B13. Apart from your employment service provider, do you know anyone who could…?

*(ROTATE STATEMENTS)

a) Help you find a job
b) Help you write a job application
c) Give you a reference for a job

d) Give you job

(RESPONSE FRAME)

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

SECTION C: EMPLOYMENT

*ALL

CINTRO: We are now going to ask you about your current or previous employment.

C1. Have you done voluntary work in the last 6 months:

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF C1=1, DONE VOLUNTARY WORK

C3. Did you do this voluntary work because…?

*(MULTIPLE RESPONSE) (ROTATE)

1. It was required as part of Centrelink payment conditions
2. I chose to for community involvement
3. I wanted to gain work experience
4. Other (Specify)
5. Unsure *(DISPLAY ONLY FOR CATI)
6. Prefer not to say *(DISPLAY ONLY FOR CATI)

*C3=4, OTHER REASON

C3Oth. What were the other reasons why you did voluntary work in the last 6 months?

1. Other Specify [TEXT BOX]

*ALL

C4. Have you ever been employed in a paid job?

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF C4=1, HAS BEEN EMPLOYED

C5. Are you currently in a paid job?

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF C5=1, CURRENTLY EMPLOYED

C6. When did you commence your current employment?

1. Month [RANGE: Jan – Dec]
2. Year [RANGE: 1975 – 2017* UPDATE to 2018 when required]
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF C5=1, CURRENTLY EMPLOYED

C7. Do you have more than one paid job?

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF C5=1, CURRENTLY EMPLOYED

C8. What is your current occupation?

Please answer below thinking about your main job, if you have more than one paid job.

*[PROGRAMMER NOTE: PRESENT JOB TITLE AND DUTIES ON SAME PAGE]

C8a. Job title *(including award/government classification if possible (e.g. secondary school teacher, metal engineering process worker, commercial property cleaner, registered nurse etc)*

1. [LARGE TEXT BOX]
2. Unsure
3. Prefer not to say

C8b. Main duties or tasks *(for example hospital duties, classroom teaching, serving customers, carpentry, concreting, cleaning, waitressing)*

1. [LARGE TEXT BOX]
2. Unsure
3. Prefer not to say

*IF C5=1, CURRENTLY EMPLOYED

C9. Which of the following BEST describes how you got your main job?

Please select only one of the options below

(READ OUT) (ROTATE)

1. Applied after seeing an advertisement (newspaper, internet, other)
2. Through connections from family or friends
3. Referred (assisted) by employment service
4. Recommended by previous employer or work colleagues
5. Directly approached an employer
6. Employer approached you
7. Unsure *(DISPLAY ONLY FOR CATI)
8. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF C5=1, CURRENTLY EMPLOYED

C10. How many hours per week do you usually work in your main job?

1. Hours per week (RANGE: 1 – 168
2. Unsure *(DISPLAY ONLY FOR CATI)
3. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF C5=1, CURRENTLY EMPLOYED

C11. If you could choose the number of hours you could work each week, and taking into account how this would affect your income, would you prefer to work…?

Please select one answer below

(READ OUT)

1. Fewer hours than you do now
2. About the same number of hours as you do now
3. More hours than you do now
4. Unsure *(DISPLAY ONLY FOR CATI)
5. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF C5=1, CURRENTLY EMPLOYED

C12. Is your main job…?

(READ OUT)

1. Permanent and ongoing contract
2. Casual or temporary employment
3. Fixed term contract (i.e. employed for a specific period of time, such as seasonal work)
4. Self employed
5. Other (Specify)
6. Unsure *(DISPLAY ONLY FOR CATI)
7. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF C5=1, CURRENTLY EMPLOYED

C13. Why are you looking for a new/another job? Is this because you are…?

(READ OUT) (ROTATE)

1. Seeking more hours
2. Required to as part of receiving income support
3. Wanting to find a different type of job
4. Other, please specify [text box]
5. Unsure *(DISPLAY ONLY FOR CATI)
6. Prefer not to say *(DISPLAY ONLY FOR CATI)
7. Not currently looking for a new job

SECTION D: PREVIOUSLY EMPLOYED PERSONS

*IF C4=1 AND C5=2, HAS PREVIOUSLY HAD A JOB BUT IS NOT CURRENTLY EMPLOYED

D1. When did you finish your last job?

Please record date below

1. Month [RANGE: Jan – Dec]
2. Year [RANGE: 1975 – 2018]
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF C4=1 AND C5=2, HAS PREVIOUSLY HAD A JOB BUT IS NOT CURRENTLY EMPLOYED

D2. How long were you employed in your last job? E.g. 2 weeks, 4 months, 2 years

1. Weeks [RANGE: 1 – 12]
2. Months [RANGE: 1 – 24]
3. Years [RANGE: 1 – 43]
4. Unsure *(DISPLAY ONLY FOR CATI)
5. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF C4=1 AND C5=2, HAS PREVIOUSLY HAD A JOB BUT IS NOT CURRENTLY EMPLOYED

D3. What was your occupation in your most recent job?

Please answer below thinking about your main job, if you have more than one paid job.

*[PROGRAMMER NOTE: PRESENT JOB TITLE AND DUTIES ON SAME PAGE]

D3a. Job title. *Including award/government classification if possible (e.g. secondary school teacher, metal engineering process worker, commercial property cleaner, registered nurse etc)*

1. Job title [LARGE TEXT BOX]
2. Unsure
3. Prefer not to say

D3b. **Main duties or tasks.** *For example hospital duties, classroom teaching, serving customers, carpentry, concreting, cleaning, waitressing*

1. Main duties or tasks [LARGE TEXT BOX]
2. Unsure

3. Prefer not to say

*IF C4=1 AND C5=2, HAS PREVIOUSLY HAD A JOB BUT IS NOT CURRENTLY EMPLOYED

D4. How did you get your most recent job?

Please select one of the options below

(READ OUT) (ROTATE)

1. Applied after seeing an advertisement (newspaper, internet, other)
2. Through connections from family or friends
3. Referred (assisted) by employment service
4. Recommended by previous employer or work colleagues
5. Directly approached an employer
6. Employer approached you
7. Other (Specify)
8. Unsure *(DISPLAY ONLY FOR CATI)
9. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF C4=1 AND C5=2, HAS PREVIOUSLY HAD A JOB BUT IS NOT CURRENTLY EMPLOYED

D5. What was the MAIN reason that you left your last job?

(ROTATE)

1. Quit: Unsatisfied, or wanted a better job
2. Contract ended
3. Made redundant
4. Was 'let go' by the employer
5. Unable to keep going to work because of transport issues
6. Health reasons
7. Other, (Specify):
8. Unsure *(DISPLAY ONLY FOR CATI)
9. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF C4=1, HAS PREVIOUSLY HAD A JOB

*PROGRAMMING: IF C5=1, CURRENTLY EMPLOYED, INSERT "OR YOUR CURRENT JOB"

D6. Thinking about any previous paid job you may have worked in (or your current job), have you experienced unfair treatment or discrimination…?

*(MULTPLE RESPONSE)

*(ROTATE STATEMENTS)

1. In the tasks you did in your job
2. In how much you are paid
3. In the supports you are given in the workplace
4. In whether or not you are promoted
5. From other employees in your workplace (such as not being included in social events or harassment)
6. From customers or clients (such as they spoke to you rudely or ignored you because of your disability or health condition)
7. Other (Specify)
8. None of the above
9. Unsure *(DISPLAY ONLY FOR CATI)
10. Prefer not to say *(DISPLAY ONLY FOR CATI)

SECTION E: HEALTH AND WELLBEING

*(SF-12 E1-E7)

E1INTRO: The following questions ask about how you feel about your health and other areas of your life. If you are unsure about which response to give to a question, please choose the one that appears most appropriate. Some questions may appear similar to the ones previously asked, however it is important to capture this information in a few different ways.

*ALL

E1. In general, would you say your health is:

(READ OUT)

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor
6. Unsure *(DISPLAY ONLY FOR CATI)
7. Prefer not to say*(DISPLAY ONLY FOR CATI)

*MHI-5

*ALL

E14. How much of the time during the past 4 weeks have you:

*(ROTATE STATEMENTS)

a) Been a very nervous person
b) Felt calm and peaceful
c) Felt downhearted and blue
d) Been a happy person
e) Felt so down in the dumps that nothing could cheer you up

(RESPONSE FRAME) (READ OUT)

1. All of the time
2. Most of the time
3. A good bit of the time
4. Some of the time
5. A little of the time
6. None of the time
7. Unsure *(DISPLAY ONLY FOR CATI
8. Prefer not to say*(DISPLAY ONLY FOR CATI)

*ALL

E10INTRO: The following questions ask about how much choice you have in your life.

E10. How much choice do you have in relation to:

*(ROTATE STATEMENTS)

a) How you spend your time
b) How you spend your money
c) Where you live
d) Who you live with
e) Who you spend time with
f) Your career or type of job

g) The types of support you currently have access to
h) Where you can obtain these supports *ALWAYS DISPLAY AFTER G (WHEN 'h' TO START THE ROTATION, SKIP TO 'a')

(RESPONSE FRAME)

(READ OUT)

1. No choice at all
2. Some choice
3. Complete choice
4. Unsure *(DISPLAY ONLY FOR CATI)
5. Prefer not to say *(DISPLAY ONLY FOR CATI)

*(ALL)

E11. Do you need help in making important decisions in your life?

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*(E11=1, NEEDS HELP IN MAKING DECISIONS)

E12. Who is the MAIN person who helps you in making these decisions?

(READ OUT IF REQUIRED)

1. Spouse / partner
2. Other family member
3. Friend
4. Professional (e.g. disability support worker, health professional)
5. Other, please specify_____
6. Unsure *(DISPLAY ONLY FOR CATI)
7. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

E13. On a scale from zero to 10, where zero means you feel no satisfaction at all and 10 means you feel completely satisfied.

How satisfied are you with…?

*(ROTATE STATEMENTS)

a) Your standard of living
b) Your health
c) What you are achieving in life
d) Your personal relationships
e) How safe you feel
f) Feeling part of your community
g) Your future security

(RESPONSE FRAME)

1. 0 – 10
2. Unsure *(DISPLAY ONLY FOR CATI)

3. Prefer not to say *(DISPLAY ONLY FOR CATI)

SECTION F: HOUSING

*ALL

FINTRO: We would now like to ask you some questions about your housing.

*ALL

F6. What type of place do you live in:

(READ OUT)

1. Private residence
2. Public housing
3. Housing co-operative
4. Shared house
5. Community small group home (e.g. residents supported by staff)
6. Supported residential service
7. Temporary accommodation (e.g. boarding house, caravan)
8. Sleeping rough (e.g. sleeping in car, couch surfing, tent / outside)
9. Other, please specify _____
10. Unsure *(DISPLAY ONLY FOR CATI)
11. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF F6≠8, NOT SLEEPING ROUGH

F3. Is the main place that you live:

(READ OUT)

1. Owned outright (either by you or someone else living in the home)
2. Being paid off by you or someone else in the household (a mortgage)
3. Being rented
4. Being purchased under a rent/buy scheme
5. Being occupied rent-free
6. Other
7. Unsure *(DISPLAY ONLY FOR CATI)
8. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF F6≠8, NOT SLEEPING ROUGH

F7. Do you personally pay any money toward the mortgage or rent?

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

[INTERVIEWER BEIEFING NOTE: CONSIDER WHETHER RESPONDENT CAN BE OVERHEARD WHEN ANSWERING AND PROBE WITH CAUTION]
*ALL

F8. We are now going to ask you some questions about how satisfied or dissatisfied you are with your current living arrangements.

How satisfied or dissatisfied are you with…

PROBE: Is that very satisfied / dissatisfied or satisfied / dissatisfied? *DISPLAY FOR CATI ONLY

*(ROTATE STATEMENTS)

a) Who you live with
b) Where you live
c) The place you live in

(RESPONSE FRAME)

1. Very dissatisfied
2. Dissatisfied
3. (Neither satisfied or dissatisfied) *DISPLAY ONLY FOR CATI
4. Satisfied
5. Very satisfied
6. Unsure *(DISPLAY ONLY FOR CATI)
7. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

F9. How many times have you moved in the last five years?

1. Times moved: [RANGE= 0 – 15]
2. Unsure *(DISPLAY ONLY FOR CATI)
3. Prefer not to say *(DISPLAY ONLY FOR CATI)

*(IF F9 1= 1 OR MORE)

F10. In the last five years have you had to move house because of your health or disability?

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF F6≠8, NOT SLEEPING ROUGH

F11. In the last six months have you experienced any period of time where you had no place to live or stay? This may include couch surfing or staying in temporary accommodation such as hotels or hostels.

1. Yes [PROGRAMMER NOTE: AUTOCODE F6=8 TO F11=1]
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

F13. Does your household have the internet connected?

INTERVIEWER NOTE: READ OUT: [PROGRAMMER TO HIDE INT NOTE FOR ONLINE]

In your response, answer Yes if this includes internet access using desktop/laptop computers, mobile or smart phones, tablets, music or video players, gaming consoles, smart TVs etc. Internet access is considered through any type of connection including ADSL, fibre, cable, wireless, satellite and mobile broadband (3G/4G).

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

SECTION G: TRANSPORT

*ALL

GINTRO: Now we are going to ask you some questions about the transport you use to get to or from places.

*ALL

G1. Do you have a driver's license that allows you to drive independently? This includes full licences or P plates but does not include learner's licences.

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF G1=1, YES

G2. Do you have access to a car or motorbike to drive **yourself** places?

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

G3. What type of transport do you use regularly?

Please select all that apply

1. Walking or motorised scooter or manual wheelchair
2. Bicycle
3. Public Transport
4. Car driver
5. Car passenger
6. Taxi
7. Motorbike
8. Other
9. Unsure *(DISPLAY ONLY FOR CATI)
10. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

G4. Do you have public transport close to home? E.g. within a 10-minute walking distance, or equivalent distance with a wheelchair or motorised scooter.

1. Yes

2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

G5. Do you have any of the following difficulties in using public transport?

Please select all that apply.

(ACCEPT MULTIPLES)

*(ROTATE) (READ OUT)

1. Difficulty getting to and from stops/stations
2. Difficulty accessing transport, such as steps
3. Lack of seating
4. Bullying / harassment
5. Lack of audio or visual messages to assist you
6. Any other problems (Specify) *FIX TO END
7. No problems accessing public transport *FIX TO END
8. Unsure *(DISPLAY ONLY FOR CATI)
9. Prefer not to say *(DISPLAY ONLY FOR CATI)

G5Oth. What other problems do you have in using public transport?

1. Other (Specify)

SECTION H: FINANCIAL SITUATION

*ALL

H1INTRO: Now we would like to ask you some questions about your income and financial situation. These are important questions because this information will give the researchers a better understanding of all the people in the survey. Your responses will be kept completely confidential.

*ALL

H6. Do you receive any of the following government benefits or allowances?

a) Newstart or unemployment benefit from Centrelink
b) Disability Support Pension from Centrelink
c) Some other benefit from Centrelink (Specify)

(RESPONSE FRAME)

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

H6OTH. What other benefit/s do you receive from Centrelink?

1. Other (Specify)

*PROGRAMMER NOTE: DISPLAY H1 AND H2 ON SAME SCREEN FOR CATI AND ONLINE

*ALL

H1. Before income tax, salary sacrifice or anything else is taken out, how much ***do you receive*** from wages or salaries? This does not include any income received as part of a government pension or benefit.

1. Amount: $ [RANGE: 0 – 100,000]
2. Unsure *(DISPLAY ONLY FOR CATI)
3. Prefer not to say *(DISPLAY ONLY FOR CATI)

*(IF H1=1, => $1, PROVIDED INCOME AND IT IS LARGER THAN 0)

H2. What period does that cover?

(READ OUT)

1. Week
2. Fortnight
3. Four weeks
4. Calendar month
5. Year
6. Unsure *(DISPLAY ONLY FOR CATI)
7. Prefer not to say *(DISPLAY ONLY FOR CATI)

*PROGRAMMER NOTE: DISPLAY H3 AND H4 ON SAME SCREEN FOR CATI AND ONLINE

*ALL

H3. Before income tax, salary sacrifice or anything else is taken out, how much ***does your household receive*** from wages or salaries? This excludes any income received as part of a government pension or benefit.

1. Amount: $ [RANGE: 0 – 500,000]
2. Unsure *(DISPLAY ONLY FOR CATI)
3. Prefer not to say *(DISPLAY ONLY FOR CATI)
4. Not applicable – single person household

*(IF H3=1, => $1, PROVIDED INCOME AND IT IS LARGER THAN 0)

H4. What period does that cover?

(READ OUT)

1. Week
2. Fortnight
3. Four weeks
4. Calendar month
5. Year
6. Unsure *(DISPLAY ONLY FOR CATI)
7. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

H5INTRO: Now we would like to ask you about any experiences you may have had with shortages of money. Your responses will be kept completely confidential.

*ALL

H5. Over the past 12 months, did any of the following happen to you because of a shortage of money?

*(ROTATE STATEMENTS)

a) Could not fill or collect a prescription medicine
b) Could not get a medical test, treatment, or follow-up that was recommended by a doctor
c) Ran out of food and could not afford to buy more
d) Could not pay a bill, such as a gas, electricity or telephone bill on time
e) Could not pay the mortgage or rent on time
f) Asked for financial help from friends or family
g) Could not fill my car with petrol
h) Could not travel when I wanted to
i) Limited my social life or my ability to go out with friends and family

(RESPONSE FRAME)

1. Yes
2. No
3. Not applicable
4. Unsure *(DISPLAY ONLY FOR CATI)
5. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

H7. Are you receiving any assistance or support through the National Disability Insurance Scheme (NDIS)?

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say*(DISPLAY ONLY FOR CATI)

*H7=1

H8. Does this package include support for you to gain or maintain employment?

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

SECTION I: ABOUT YOU

*ALL

I10. Thinking now about your schooling and education.

What type of school did you attend for most of your schooling?

1. Mainstream
2. Special school
3. Integrated (e.g. special classroom in mainstream school)
4. Other, please specify _____
5. Unsure *(DISPLAY ONLY FOR CATI)
6. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

I11. What is the highest level of schooling you have <u>completed</u>?

1. Year 12/13 or equivalent (e.g. VCE, VCAL)
2. Year 11 or equivalent
3. Year 10 or equivalent
4. Some high school but less than year 10 or equivalent
5. Primary school or less or equivalent
6. Did not go to school
7. Unsure *(DISPLAY ONLY FOR CATI)
8. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

I12. After leaving school what is the highest qualification you have completed?

(READ OUT)

1. Have not completed any additional qualifications
2. An apprenticeship or trade certificate (Certificate III or IV)
3. Other certificate level (Cert I – IV)
4. Associate degree or diploma
5. University degree (e.g. bachelor degree, postgraduate degree or diploma)
6. Unsure *(DISPLAY ONLY FOR CATI)
7. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

I12b. Are you currently doing any formal study or training that leads to a recognised qualification like a degree, diploma, or certificate?

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*ALL

I13. Thinking about the survey you have answered today, is there anything you would like to add about your experience of looking for work?

1. OPEN (Record)
2. No, no further comment
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*(ALL)

*PROGRAMMER NOTE: IF ONLINE USE FIRST TEXT / IF CATI USE SECOND TEXT

PROXYSTAT. Which of the following best describes how you completed this survey / DO NOT READ: How did the respondent complete the survey?

1. (I completed on my own / Respondent completed on their own)
2. (Someone else helped me / Respondent had someone assist for some of the survey)

SECTION J: FOLLOW UP

*ALL

INCENT Thank you for your time completing this survey. As a small token of our appreciation, we would like to send you a $10 Coles gift card. We can send this to you via email so that you receive it soon after you complete this survey. We will only use your email address for this purpose unless you specify otherwise.

1. First name: (FNAME)
2. Last name (optional): (LNAME)
3. Email address: (EMAIL)
4. Prefer not to receive gift card
5. Prefer to receive gift card via mail

*(INCENT=3, PROVIDED EMAIL)

EML Before we send the email with your incentive, please confirm the below is correct.

*DISPLAY EMAIL FROM INCENT

1. Email address is correct
2. Go back and correct email address

*(PROGRAMMER NOTE: IF EML=1, insert into V6 list: 461184)

VISION 6 API KEY: e6f3e625c66a94a00607ae63b4518678e6f27c6f0596649173838f9bb4509ea8

Variables to add: recordid, fname, email, e-card link, pin.

*INCENT=5, PREFER INCENTIVE VIA POST

MAIL. So that we can post your $10 gift card, can I please have your mailing address? Please allow up to four weeks for processing and delivery.

Indicates mandatory fields

1. First name*:
2. Last name*:
3. Street address 1*:
4. Street address 2:
5. Suburb*:
6. State*:
7. Postcode*:
8. Return to previous question to provide email

*ALL

J1. We would like to contact you again in twelve months to ask you some more questions about your experiences with employment service providers and working or looking for work. This survey will be a similar length to today's and can be done online or over the phone. Are you happy for us to contact you in approximately 12 months? You can choose not to participate at the time.

1. Yes
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF J1=1

J1CONSENT: Thanks for that, can you please confirm your details so that we may re-contact you some time in the future?

*(PROGRAMMER: AUTOFILL THESE DETAILS FROM THE ENROLMENT FORM, ALLOW FIELDS TO BE EDITABLE)

(INTERVIEWERS: UPDATE AND ADD DETAILS WHERE APPLICABLE)

Indicates mandatory fields

1. First name*:
2. Last name*:
3. Address line1:
4. Address line 2:
5. Best contact number*:
6. Alternative contact number:
7. Email:

*ALL

J2. The researchers from the University of Melbourne conducting the study may also wish to follow up with some people to ask further questions about the subject matters covered in today's survey. This may take place over the phone or in person (face to face) for around 60 minutes.

A researcher would contact you with more specific information closer to the time to help inform you of what will be required. You may change your mind at any time.

By saying 'yes' you consent to the Social Research Centre passing your contact details to the researchers at the University of Melbourne for the purposes of possibly contacting you for further research.

1. Yes, agree to have contact details passed to University of Melbourne researchers to be contacted for further research
2. No
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

*IF J2=1

*PROGRAMMER: AUTOFILL RESPONSES GIVEN AT J1 IF J1=1. INSERT 'PROVIDE' IF J1 = 2,3,4, IF J1=1 INSERT 'CONFIRM'

J2CONSENT: Thanks for that, can you please (provide / confirm) your details so that we may re-contact you some time in the future?

Indicates mandatory fields

1. First name*:
2. Last name*:
3. Address line 1:
4. Address line 2:
5. Best contact number*:
6. Alternative contact number:
7. Email:

*IF J1=1, YES TO RECONTACT

BUDDY: In case we lose contact with you, please provide the name and contact details of two relatives or friends who we might be able to call. We would only contact these people if there was no way of reaching you. We would simply call them to ask if they are able to provide your current contact details.

The Social Research Centre will contact your nominees to let them know their details are being stored for this purpose.

1. Yes, ok to provide contact detail for additional person(s)
2. No, would prefer not to provide contact details
3. Unsure *(DISPLAY ONLY FOR CATI)
4. Prefer not to say *(DISPLAY ONLY FOR CATI)

5. Call back to collect buddy details

*IF BUDDY=5, CALL BACK INTRO

BUDDYINTRO: Hi my name is <NAME> calling on behalf of the University of Melbourne from the Social Research Centre. May I please speak with <QR NAME>?

You recently helped us by completing a survey about improving employment services. At the end of the survey, we asked if you could provide the name and contact details of two relatives or friends who we might be able to call if we had trouble reaching you.

We would simply call them to ask if they are able to provide your current contact details.

We will contact your nominees to let them know their details are being stored for this purpose. Are you happy for us to collect these details?

1. Yes, ok to provide contact detail for additional person(s)
2. No, would prefer not to provide contact details

*IF BUDDY=1 OR BUDDY INTRO=1

BUDDY1: Person 1

1. Name*:
2. Relationship to you:
3. Best contact number*:
4. Alternative contact number:
5. Email:

*IF BUDDY=1 OR BUDDY INTRO=1

BUDDY2: Person 2

1. Name*:
2. Relationship to you:
3. Best contact number*:
4. Alternative contact number:
5. Email:
6. Prefer not to provide details for second person

*ALL

END1. Thank you for taking the time to complete this survey. Your insight and information are invaluable to helping us gain a better understanding of employment and health and wellbeing for people with disability.

*CATI ONLY:

This research was carried out in compliance with the privacy act. Just in case you missed it my name is [intname] calling on behalf of the University of Melbourne from the Social Research Centre. If you have any queries or concerns about the project I can provide you with the details of the research team.

1. Continue, submit survey
2. Wants research details / ethics details *DISPLAY ONLY FOR CATI

*IF ONLINE END1=1 OR END1=2

DETAILS. If you are having any reactions such as distress or upset to the interview process, or if you have any questions about the research, you can contact the researcher using the contact details below.

Researcher: Stefanie Dimov

Email: stefanie.dimov@unimelb.edu.au

Phone: (03) 9035 4554

If you have any concerns or complaints about the conduct of this research project, you can contact the Manager, Human Research Ethics, Research Ethics and Integrity, The University of Melbourne by phone 8344 2073 or email humanethics-complaints@unimelb.edu.au quoting Ethics ID 1545810.

TERM SCRIPTS:

Term 1: Thank you for your time, we are only able to conduct interviews in English at this time.

Term 2: Sorry for the call, we won't contact you again.

Term 3: Thanks for your time, for this study we need to speak with people who have had recent contact or support with a provider.

ALLTERM

Termination	Description	Summary Outcome
Intro = 3	Household Refusal	Refusal
Intro = 4	Respondent Refusal	Refusal
Intro = 7	Language difficulty	Out of Scope
SAFE1 = 3	Refused safety question	Refusal
ETHICS = 2	Refused ethics	Refusal
PLSINFO=3	Refused participation	Refusal

BUDDY NOTIFICATION

*IF BUDDY=1 OR BUDDY INTRO=1

*FOR EACH OF BUDDY1 & BUDDY2 (BUDDY2 ≠ 6) CONTACT THEM VIA:

*EMAIL IF PROVIDED

*SMS IF PHONE BEGINS WITH 04 AND EMAIL NOT PROVIDED

*TELEPHONE IF NO MOBILE NUMBER (PHONE DOESN'T BEGIN WITH 04) AND EMAIL NOT PROVIDED - SET AS APPOINTMENT

BUDDY CONTACT SCRIPTS:

EMAIL SCRIPT:

Dear <BUDNAME>,

<FIRSTNAME> recently took part in an important research project with the University of Melbourne and the Social Research Centre and have agreed to take part again in 12 months time.

In case we have difficulty contacting them in future, <FIRSTNAME> was asked to provide the contact details of a relative or friend who could be contacted if they are unreachable. They nominated you as their <RSHIPSTAT> and provided us with your name and contact details (email address <and phone number>). Your details will NOT be used for any other purpose and are protected under Australian Privacy Principles.

If you are happy for us to keep your details on file for this purpose only, you do not need to do anything.

If you would like your details to be removed and not used for this purpose, please reply to this email or call the Social Research Centre on 1800 023 040 to let us know.

Kind regards,

SMS SCRIPT:

Hi <BUDNAME>, <FIRSTNAME> recently took part in a research project for the University of Melbourne and the Social Research Centre. They agreed to participate again in 12 months and advised us to contact you if they are unreachable. Your details will be stored securely and used only for this purpose. Reply "1" or call the SRC on 1800 023 040 to have your details removed.

CATI SCRIPT

Hi, my name is <NAME> calling on behalf of the University of Melbourne from the Social Research Centre. May I please speak with <BUDNAME>?

<FIRSTNAME> recently took part in an important research project with the University of Melbourne and the Social Research Centre and agreed to take part again in 12 months time.

I'm calling to let you know that they nominated you as their <RSHIPSTAT> and provided us with your name and phone number in case we have any trouble reaching them in the future.

Your details will NOT be used for any other purpose and are protected under the Australian Privacy Principles.

If you are happy for us to keep your details for this purpose only you do not have to do anything. Please let me know if you would like your details to be removed and not used for this purpose.

1. Keep buddy contact details
2. Remove buddy contact details

Appendix 2. IDES Participant capacity to consent checklist

This information sheet details the capacity to consent checklist to ascertain whether the job seeker has the 'capacity' to provide their own consent to participate in the study or if contact with a proxy should be sought. This 'form' below will be integrated into the telephone and online survey.

- The person is able to understand what the study is about when it is explained to him/her.

  Yes/No

- The person understands what they will be doing as that the study involves participating at multiple time points. Yes/No
- The person knows that it is up to them only to decide to be in the study. Yes / No
- The person understands that participating in the study may not directly benefit them as an individual. Yes/No
- The person understands the risks and inconvenience involved in being in the study. Yes/No
- The person knows they can withdraw at any time or decide not to do certain things. Yes/No
- The person knows they can complain about the study to any one of the following people:
  - to someone they know well;
  - to their employment services provider;
  - to the Social Research Centre; or
  - to the Ethics Officer at the University of Melbourne. Yes/No
- The person usually makes decisions about things impacting on his/her life or activities. Yes/No

If ALL the above statements are "true" for the job seeker, consent can be sought from person. If ANY statement is "not true" or you are unsure about ANY of the above statements, then consent should be sought from a proxy.

Appendix 3. Interview guide for initial interview with job seekers

1. Demographic information

Participants name	
Date of birth Day/Month/Year	
Gender	
Ethnicity	
Address	
Interview Day/Month/Year	
Location of interview	
Employment service	
Type of income support	

2. **Can you tell me a little bit about yourself?** (Probes: where were you born, who did you grow up with (parents, siblings?), where did you grow up? Do you live with family now? How do you spend your time day to day? What do you enjoy doing?)

3. **Can you tell me a little bit about your physical health?** (Probe: any health conditions, access to health services, management of health conditions)

4. **Can I ask you about your mental health?**
    a. **Have you been diagnosed as having a mental health condition?** If so, are you happy to tell me about your diagnosis? (Probes: what age were you diagnosed, what services/support are you accessing, nature of condition?)
    b. **Can you tell me if/how your mental health has impacted/impacts on your life?** (Probes: family, friendships/other relationships, health and well-being, education, recreation, financial matters, housing)

5. **I would now like to ask you some questions about work?**
    a. **Are you currently working/or have you previously worked?** If so, what do you do for work? (Probes: If working, does current work relate to previous training/experience? What do you like about the kind of work you do/are looking for? Is there anything that is difficult/challenging?)
    b. **What role does work play in your life? (**Probes: importance of work in relation to financial circumstances, social impact, health and well-being?)

6. **How do you feel your mental health has an impact on your work?** (Probes: type of work, hours, managing stress, disclosure regarding mental health)

7. **Can you tell me what you feel are the most significant barriers you experience in regards to gaining/maintaining work?** (Probes e.g.: housing, transport, managing mental health or other health conditions, fear or experiences of discrimination, education, work experience, skills, income support, family commitments, accessing services, availability of appropriate jobs)

8. **Do you currently receive any support to help you address these barriers?** (Probes, if so, what support? Who provides this support?)

9. **What sort of work would you like to do now or in the future?** (Probes: reasons why, what would help you gain this work, what might make it difficult?)

10. **Can we now talk about your access to Employment Services?**
    a. **How long have you been accessing Employment Services?** (Probes: is [name of current Employment Service] the first Employment Service you have seen? If no, which other Employment Service have you previously seen?
    b. **Did you choose to come to the Employment Services you are currently seeing?** If yes, probes: why did you choose to come to this Employment Service? What helped you make this decision? Did you experience any difficulties in choosing an Employment Service? Is there anything that would have made this process easier? If did not choose, who referred you to this Employment Service?
    c. **Would you ever consider changing Employment Services?** If yes, probes: what are some of the reasons you might consider changing? How might you go about changing? If no, are there any reasons why you would not consider changing Employment Services?

11. **I would now like to ask you some questions about the support provided by your Employment Service?**
    a. **How has your Employment Service worked with you to help you gain work?** (Probes: discussing what work you would like to do, preparing CV, job searching, preparing for interviews, accessing further training/education, job readiness preparation, referral to other services, transport)
    b. **How do you think these activities are helping to address some of the barriers you experience in gaining/maintaining work?** (Probe: discuss barriers previously mentioned. If so, what do you find most helpful? If not, how do you think the Employment Services could improve the help they are providing to address these barriers?)
    c. **How do you think these activities will help you gain the sort of work you are hoping to gain?** (Probes: do these activities support you gain work that meets your interests/aspirations/skills/work capacity? Support to address barriers to work)
    d. **How do you think these activities help you in your life more generally?** (Probes: e.g. has this helped you improve your health/well-being, housing, social networks?)

12. **Is there anything that you think makes it difficult for the Employment Service to help you address barriers you experience to gaining/maintain work?** (Probe: time, availability of referral services, skills of staff, mental health condition, availability of work, or other life circumstances?)

13. **Do you receive any support from other people to help you gain/maintain work, outside of the Employment Service?** If so, can you tell me how these other people help you? (Probe: e.g. family, friends, colleagues, teachers, business owners)

14. **The final questions I would like to ask you are about 'choice and control'. Are you aware that the government are hoping to increase 'choice and control' for job seekers in their interactions with Employment Services?** (Probe: e.g. you will be given more choice about which Employment Services you access, you will be able to change Services if you want to)
    a. **What does 'choice and control' mean to you?**
    b. **How do you feel you currently have 'choice and control' in your interactions with Employment Services?** (Probe: e.g. choosing which Employment Service you access, how often and how you meet with staff, the type of support provided to you, support to pursue work of your choice?)

c. **Can you tell me about how you have 'choice and control'/make decisions in other aspects of your life?** (Probe: where you live, what services you access, how you spend your money, what you do each day?)
d. **Is there any thing that makes it difficult for you to have 'choice and control' in your interaction with Employment Service?** (Probe: time, available information, general decision making)
e. **How do you feel Employment Services could help improve your 'choice and control'?** (Probe: time, available information, support for decision making, developing skills in decision making?)

Thank you very much for your time today and for telling me about your life and engagement with Employment Services. Do you have any questions you would like to ask me? Or is there anything you would like to discuss with me today?

Sometimes people can become upset after taking part in an interview about their life. Do you mind if I contact you in a few days' time to see how you are feeling?

If before or after this time you do feel upset or would like to talk to someone about how you are feeling, I have some information about people you can contact and talk to.

I am also wondering if you would be happy for me to contact you in about six months' time to see if you would be interested in participating in a follow-up interview.

Appendix 4. Interview guide for follow up interviews with job seekers

1. Demographic information

Participants name	
Date of birth Day/Month/Year	
Gender	
Address	
Interview Day/Month/Year	
Location of interview	
Employment service	
Type of income support	

2. **Can we start by talking about whether there have been any major changes in your life since we last met?** (Probe: e.g. health, family, housing, change in Employment Service)
3. **Have you been working since we last met? *(If no go to questions from 3b).* Can you tell me about the work?** (Probe: e.g. role, length in time, recruitment process, alignment with aspirations, positive and/or negative aspects)
4. **Can you tell be about how the Employment Service supported you to gain work?** (Probe: e.g. activities undertaken, job search, interview preparation, referral to other services)
5. **What was the most effective support the Employment Service provided to help you address barriers you were experiencing to gain work?** (Probe: e.g. mental health, housing, transport, skills training, networks)
6. **Were there any other people/services/factors which you feel helped you gain work?** (Probe: e.g. family or social networks)
7. **Is there anything that may make it difficult for you to maintain this employment?**
8. **Can you tell me about how the Employment Service continues to support you to maintain this employment?** (Probe: e.g. skills training, transport, supporting negotiations with employer)
9. **Is there any other people/services/factors which you feel will also help you maintain this employment?**
10. **We talked last time about job seeker 'choice and control' in their engagement with Employment Services** (Probe: e.g. highlight what job seeker discussed in initial interview). **Thinking about the last six months, can you tell me about your 'choice and control' in your engagement with the Employment Service?** (Probes: e.g. how and how often you met, how and what support was provided to you, changing providers, pursuing work that was of interest to you).
11. **How do you feel Employment Services could help improve you have more 'choice and control'?** (Probes: time, available information, support for decision making, developing skills in decision making?)
12. **Can you tell me about how engaging with Employment Services has impacted on your life?** (Probes: support to address barriers to employment, health and well-being, access to employment, social networks, any negative impacts?)
13. **Can you tell me about how working has impacted on your life more broadly?** (Probe: e.g. financial, family, social, housing, health and well-being)

For job seekers who have not engaged in work since initial interview.

3b. Can you tell me about how the Employment Service has tried to support you to gain work? (Probe: e.g. activities undertaken, job search, interview preparation, referral to other services)

4b. Can you tell me about what barriers to employment you continue to experience? (Probes: e.g. housing, transport, managing mental health or other health conditions, fear or experiences of discrimination, education, work experience, skills, income support, family commitments, accessing services, availability of appropriate jobs, why do these barriers remain?)

5b. What else do you feel you and the Employment Service can do to help you address these barriers to work?

6b. We talked last time about job seeker 'choice and control' in their engagement with Employment Services (Probe: e.g. highlight what job seeker discussed in initial interview). **Thinking about the last six months, can you tell be about your 'choice and control' in your engagement with the Employment Service?** (Probes: e.g. how and how often you met, how and what support was provided to you, changing providers, pursuing work that was of interest to you).

7b. How do you feel Employment Services could help improve your 'choice and control'? (Probes time, available information, support for decision making, developing skills in decision making?)

8b. Can you tell me about how engaging with Employment Services has impacted on your life? (Probes: support to address barriers to employment, health and well-being, access to employment, social networks, any negative impacts?)

9b. Can you tell me about how you feel your life has been impacted by not finding work in the last six months? (Probe: e.g. financial, family, social, housing, health and well-being)

Thank you very much for your time today and for telling me about your life and engagement with Employment Services. Do you have any questions you would like to ask me? Or is there anything you would like to discuss with me today?

Sometimes people can become upset after taking part in an interview about their life. Do you mind if I contact you in a few days' time to see how you are feeling?

If before or after this time you do feel upset or would like to talk to someone about how you are feeling, I have some information about people you can contact and talk to.

Are you interested in receiving a summary of the findings from this study? If so, we can send a copy via email or to your home address.

Yes, the participant would like to receive a copy of the plain language summary

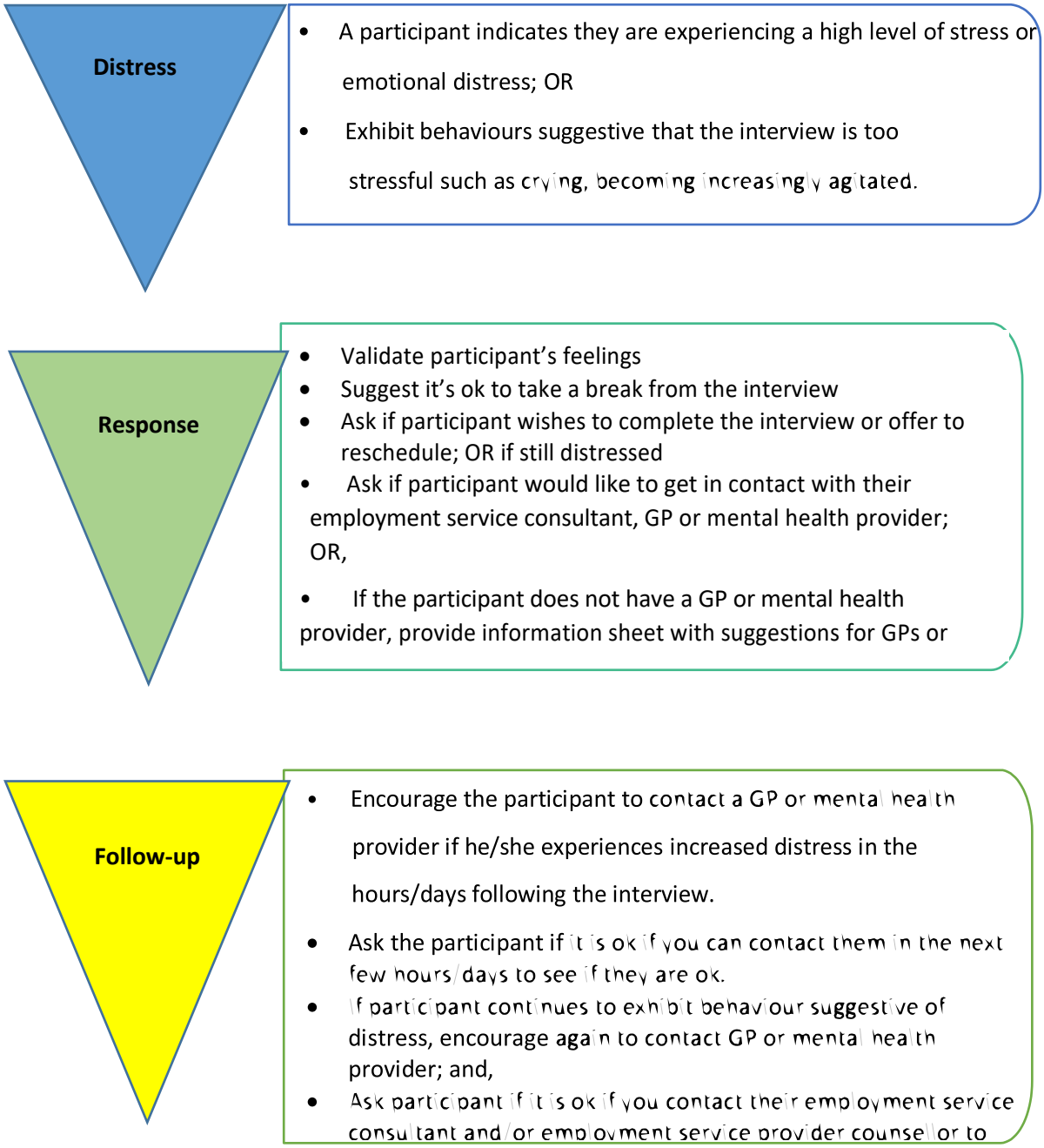
Via email: _____

Via home address: _____

_____

No, the participant would not like to receive a copy of the plain language summary.

Appendix 5. Project Distress Protocol



Appendix 6. Qualitative component Plain Language Statement

Information for potential participants

There is a new research project happening in the Disability Employment Services sector. This project is called the "**Psychosocial Disability and Employment Services"** project.

This research project is being conducted by the University of Melbourne in partnership with Employment Services.

Would you like to be involved?

This information sheet gives you more information about the project. It is for you to keep. It is up to you if you would like to be involved.

What is the research project about?

We want to learn more about the lives of job seekers and what is important to them when they access Employment Services. We are particularly interested in learning more about job seekers with mental health conditions, sometimes referred to as psychosocial disability.

Why are we doing this research?

We know that job seekers with disabilities can experience challenges finding work. We would like to listen to job seekers and learn more about what they think Employment Services can do to help them find work. We would also like to understand how working might impact of the lives of people with disabilities.

Researchers at the University of Melbourne, as well as Employment Services, want to understand how to improve access to work for job seekers with disabilities. However, this project will not necessarily result in participants finding work, nor can it guarantee how services will be provided in the future.

What will you have to do?

The researcher is inviting job seekers from your Employment Service to be involved. The researcher will start by meeting with you and talking about the research project. This is so we can get to know each other and you can find out more about the research project. This will help you decide if you want to be involved.

If you do want to be involved, we can then organize a time to meet with you to do an **interview**, where we will ask you to **talk about your life** and about your experiences of looking for work and with Employment services. You can bring along a family member or friend to support you during the interview if you would like to. In the interview we will ask you questions like:

1. Can you tell me a little bit about your health?
2. Can you tell me about some of the difficulties you have experienced when trying to find work?
3. Can you tell me a little bit about what support the Employment Service is providing you?
4. What is the most important help you receive from your Employment Service?

We hope to do two interviews with you. One in the coming days or week, and another interview in about six months' time. Each interview will take about 60 to 90 minutes. These interviews will be done in a quiet, comfortable place where you feel comfortable. This might be at a local café or at the Employment Service in a private office.

What do I need to know if I would like to be involved?

It is up to you if you would like to talk to the researcher. If you would like to be involved, we will ask you to provide consent which is a record that you agree to be part of the project. If you start talking and then you change your mind, that's ok too. If you don't want to be part of the project, or you start but then decide to stop, you WILL NOT be disadvantaged in any way.

A family member or someone you trust can be there when we talk. This way they can support you and make sure you are comfortable with what we are talking about.

When you talk to us, we will audio record what you say and may also write down some notes. We will not write your name on these notes. Your words will be private and no one will know it was you that said those words.

It is free to be involved.

What are the possible benefits if I participate?

The researcher is interested in what you have to say. This is a good opportunity for you to talk about important things in your life. This will help Employment Services and researchers better understand about job seekers and how to better support access to work. You can also receive a copy of the research project findings. If you do participate, you will receive a $20 gift voucher for each interview to compensate you for your time and any costs associated with participation (e.g. travel).

What are the possible risks if I participate?

This project is based on conversations with you and the researcher. You might talk about a difficult experience and this may make you feel sad. However if that happens, we can have a break from the conversation and talk about something that makes you feel happier. We will help you to feel safe and comfortable and the researcher and your employment consultant can provide follow up support.

Who are the researchers?

The researchers are from the University of Melbourne:

1. The researcher you will talk to is called Alexandra Devine. Alexandra has been a researcher for more than ten years. She is doing this research project as part of her PhD.
2. Alexandra is being supervised by Professor Anne Kavanagh and Dr Cathy Vaughan. Anne and Cathy are also researchers and will help Alexandra to plan the research.

Who is paying the researchers to do the research?

This research project is part of a larger project called the Improving Disability Employment Study (IDES). IDES is being funded by the Australian Research Council with support from Employment Services and other organisations such as the National Disability Services.

Who do I contact if I want to be involved or know more about it?

You, your family or support person can contact the following people if you would like to know more about the research:

1. Ms. Alexandra Devine, Melbourne School of Population and Global Health, The University of Melbourne.
   Telephone: 03 8344 1632
   Email: devinea@unimelb.edu.au

2. Your employment consultant at [name and contact details of Employment Service staff member]

3. Professor Anne Kavanagh, Melbourne School of Population and Global Health, The University of Melbourne.
   Telephone: 03 8344 0717
   Email: a.kavanagh@unimelb.edu.au

4. Dr Cathy Vaughan, Melbourne School of Population and Global Health, The University of Melbourne.
   Telephone: 03 9035 6670
   Email: cmvaug@unimelb.edu.au

Who do I contact if I am not happy with something or want to complain about the research?

You can talk to the researchers directly and talk about your worries.

If you want to talk to someone like a manager, please call or email:

Ms Stefanie Dimov, IDES Project coordinator at the Melbourne School of Population and Global Health, The University of Melbourne:

Telephone: 03 9035 4554

Email: stefanie.dimov@unimelb.edu.au

If you would like to contact the people who approved this project, please contact:

Executive Officer, Human Research Ethics, The University of Melbourne, Australia

Telephone: +61 3 8344 2073

Please quote project number: 1750133.1

Appendix 7. Qualitative component Informed consent form

Project title: Psychosocial disability and Employment Services

Dear participant,

Please read this form carefully. Please tick the box next to each statement that you understand. If there is anything that you do not understand, or would like to know more about, please ask for more information. Once you have confirmed that you understand each statement, please sign the bottom of the consent form.

ID No. of participant: _____

Information	**I agree**
1. I have read, or have had the Plain Language Statement read to me, in a language that I understand, and I understand the purpose, processes and risks of this research project.	
2. I understand that after I sign and return this consent form it will be kept by the researcher.	
3. I have had an opportunity to ask questions and I am satisfied with the answers I have received.	
4. I freely agree to participate in this research and I understand that my participation will involve participating in two interviews of approximately 60-90 minutes in length.	
5. I acknowledge that: ▪ participation in this project is voluntary and I am free to withdraw from the project at any time without explanation or prejudice, and to withdraw any information that I have provided; and ▪ the project is for the purpose of research.	
6. I have been informed that the confidentiality of the information I provide will be protected.	
7. I have been informed that I can request a copy of the research findings.	

Signature of participant: _____

Date: _____