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LITERATURE REVIEW

SUPPORTING YOUNG PEOPLE WITH A MENTAL
ILLNESS IN THEIR TRANSITION FROM
EDUCATION INTO THE WORKPLACE

Prepared for the National Mental Health Commission
September 2013

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September 2013

ACKNOWLEDGEMENTS

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1. EXECUTIVE SUMMARY

For many young Australians, adolescence is a stormy time. From a developmental perspective, young people are in the process of forming their identity including trying out different school, post-school work and study options. Youth transitions involve young people (aged 15 to 24 years) moving between school, post-school study and employment. For around half of all young people, this transition remains relatively straightforward (Furlong 2009). However, for others, this does not go smoothly and involves periods of unemployment, underemployment where they may work for fewer hours than they would prefer, or work in low-paid, low-skilled jobs with limited prospects for progression. For a majority of affected young people this is only a temporary state, but for others it persists, and can have long-term consequences. Early experiences of unemployment or weak labour market attachment have been found to increase the likelihood of subsequent and continuing periods without paid work (Sweet 2012a).

This report focuses on young people aged 15-24 living with or at risk of mental health conditions and how this affects the transition from school to further education and work. The consequence of mental illness at this age can be particularly problematic and, long lasting. The report also highlights the evidence underpinning programs aimed at increasing the likelihood of a successful transition

1.1. MAIN FINDINGS FROM THE LITERATURE REVIEW

The mental illness - transition connection

- There is an association with not being in employment, education or training (NEET) in youth and later life disadvantage.
- The transition from school to work coincides with the onset of many mental health disorders.
- Young people in post-secondary education report experiencing very high levels of psychological distress, which can negatively impact their studies and place them at greater risk of attrition, yet only a minority seek help.
- Young people with mental illness have lower rates of engagement in employment, education or training than young people without mental illness.
- There is no single defining set of characteristics of young people who are, or at risk of becoming, disengaged – the reasons are varied and complex. However, there are identified influential factors including personal or family related financial hardship, low parental engagement, experience of violence, and poor experiences at school.
- While there is less evidence that mental illness is a consequence of NEET status, there is evidence to suggest disengagement from education and employment is associated with psychological distress.
- The majority of engagement programs do not adequately screen for, or respond to, mental illness, largely relying on referrals for those whose struggles are more evident.

Intervention: School to further education

- There is little rigorous research on how to better support young people with mental illness into and during post-secondary education.
- Strength based and recovery based approaches are preferable to ones that focus on deficits.
- Schools can be an effective site for prevention and early intervention of mental health illnesses.
- Families play a critical role in the development of childhood and later life resilience and protective factors for mental health.
- Systematic reviews demonstrate mixed evidential support for Supported Education initiatives with a need for more rigorous evaluations.

- Alternative education programs may potentially have a promising role in reconnecting young people who are disengaged from education; however, the evidence base is lacking and they do not reduce the need for improving support in mainstream schooling.

Intervention: Education to Employment

- There are numerous documented barriers to participation in work for people with mental illness.
- For people with severe mental illness the strongest evidence supports a preference for early mainstream work placement, and a reduced emphasis on prevocational training, with the most prominent model being the Individual Placement and Support (IPS) model. However, much of the evidence is based on adult models and does not sufficiently account for the potential differences in preferences and needs of younger people. Furthermore, there is recognition that this approach does not work for everyone and that there may be barriers to implementation in Australia.
- There is general support for better integration of vocational and mental health services, including co-location and improving intersectoral links.
- Despite the high prevalence of mild-moderate mental health conditions, there is very little literature on how to provide better support for the education employment transition of young people with mild-moderate mental illness.
- The literature on sustaining work for people with mental illness is very sparse. More research is needed on how to better support employees with mental health conditions as well as how to assist employers in facilitating participation.
- Outreach, integrated support and comprehensive 'packages' appear to be more successful than standalone assistance in improving the transition from school to work and addressing disengagement.
- Intermediaries such as group training organisations may be better placed than businesses to provide transitional support into work by addressing information asymmetry and providing continuity.
- There is some evidence that mentoring and pastoral care may assist the transition into work and improve work readiness.
- Support in work and education is often predicated on disclosure of mental illness, however, there are considerable barriers against such disclosure. There needs to be more done to better support disclosure and to provide support prior to disclosure.
- Although there is increasing focus in policy and practice on the importance of supporting young people with mental illness in the school to work transition as well increasing recognition of the individual needs and rights of people with mental illness and disability. A major concern is inadequate rigorous evaluation of policies and intervention programs aimed at enhancing this transition.

1.2. CONTENTIONS

Contentions identified in the literature included:

- **Classification and Labelling of Youth:** There are concerns raised about the negative and potentially stigmatising implications of some of the terminology used to describe vulnerable young people.

- **Deficits versus Strength based approaches:** There are concerns that a focus on deficits and risk factors only results in further stigmatisation for vulnerable youth. There is growing acceptance that a strength based approach is more empowering for young people; however, there is still considerable use of deficit approach both in research and in practice.

- **The role of young people:** There is still considerable contention about the role of young people as they transition from school to work and their available choice, responsibility and power. There is a push for greater democratisation to give young people more of a say in the decisions that affect them, however, often young people are still subjects rather than active participants in research and practice.

- **Who is responsible:** This is particularly an issue around disclosure, where people with mental illness are often required to disclose issues in order to receive support despite the evidence of the considerable barriers to disclosure. It remains a point of contention as to how much personal responsibility is required from the individual and how much responsibility for care should be assumed by the system.

- **The capability of people with mental illness:** There are still many misconceptions and uncertainties about the capabilities of people with mental illness around employment and education. The literature suggests that mental illness does not necessarily predict performance and there is growing evidence to show that many people with severe mental illness are able to participate in mainstream work and education, yet there can reportedly still be reluctance to encourage that participation out of concern that it may be detrimental to the person attempting it.

- **Mainstream versus separated support:** There is trend towards supporting mainstream inclusion, however, there is concern that this may not be appropriate for all people.

- **How to integrate of vocational and mental health services:** Generally, there is strong support for the benefits of integration. However, there is some contention on the preferred model of integration between co-location or improving intersectoral links. There is also acknowledgment that there is a role for both approaches.

- **Role of training:** There is evidential support to preference "place and train" models over "train and place" models for adults with mental illness – that is, limit pre-vocational training and focus on getting people into work and then provide job relevant training. However, there is uncertainty if and how this should be modified for younger people. The emerging literature suggests that there may be a greater need for prioritising and supporting educational goals for younger people.

- **What is valued:** Conversely, there is also the concern as to whether evaluations of initiatives can be too narrowly focused on economic outcomes and fail to recognise other value that might be derived. For example, a number of programs failed to find significant improvements in rates of employment or education entry but participants reported appreciation of the programs and gaining value.

1.3. GAPS

There are many gaps in the understanding of the issues and support for young people with mental illness in the transition from school to work. This is an area where there is an urgent need for research to inform policy and practice. The most obvious gap is the lack of high quality evidence (NHMRC grades I, II or even III-1 for interventions) limiting the ability to make recommendations. Work placement, in particular IPS is the standout exception to this.

Prominent gaps identified include:

- **How to support young people who are often in the early stages of diagnosis:** There is very little in the literature that examines young people who may be experiencing onset of mental illness in the school to work transition. To date, much of the literature on supporting people with mental illness at work focuses on older adults.

- **Supporting people with mild-moderate mental health conditions:** There is a significant gap in our understanding of how to provide better support for people with mild-moderate mental health conditions despite the large number of people in this group and the availability of effective treatment. Far more is known about supporting people with severe mental health conditions.

- **Supporting especially vulnerable groups:** There is insufficient research on the effects of a range of characteristics that may further disadvantage a young person with mental illness and subsequently, research on how to provide better support for individual needs.

- **Supporting mainstream participation:** While there is support in the literature for a preference for mainstream participation where appropriate, there is little to inform how to support mainstream participation.

- **Supporting employment retention, not just entry:** The greater focus in the literature has been on entry into employment, and there is very little on how to better support employment retention.

- **Supporting those who don't respond to vocational interventions:** There is often very little reported follow up of those who don't respond to vocational interventions to explore why an intervention may not have worked and what alternatives were available. This is of particular concern given that many interventions that are viewed as 'successful' still have high numbers of people for whom the intervention was deemed unsuccessful.

- **Supporting the transition into post-secondary education:** Possibly as a result of a focus on adult vocational needs, there is inadequate research on supporting young people's potentially different vocational goals and the greater importance that may be placed on education.

- **Providing support without disclosure:** It is well documented that there are considerable barriers to disclosure in education and employment, however, provision of support is often predicated on a requirement for disclosure. Despite this, there is little research that can inform how support can be provided where disclosure has not been provided.

- **Improving disclosure rates:** The research suggests that disclosure is rarely a free choice but forced on an individual. There needs to be more research on how to better support and encourage disclosure.

- **Workplace accommodation/modifications for psychiatric disability, especially for the young:** In comparison to physical disabilities, far less is known about what workplace accommodations/modifications may be appropriate or feasible for people with psychiatric disability.

- **Workforce development to provide better support:** The literature frequently reports a skills gap in either vocational or educational staff requiring mental health skills or conversely, mental health professionals requiring better vocational skills.

- **Improved coordination of services:** There is support for the benefits of better coordination of services, however, this is still far from generally implemented. There is also a need for more research to inform how to improve coordination and develop models of care.

- **Regular collection of data on young people's mental health:** There is no regular survey or data collection process to collect data on young people's mental health. The picture of young people's mental health must be pieced together from a range of data sources.

- **Consumer voice and lived experience:** Too often in the literature, the preferences and lived experiences of young people with mental illness are just not included. There needs to be improved inclusion of young people's voices to better inform research, policy and practice.

1.4. PRIORITIES

The literature review identified the following priorities to better support young people with mental illness in the transition from school to work:

- Identified gaps in research and practice need to be urgently addressed.
- Active inclusion of the voices of young people with mental illness in all aspects of research, policy and practice.

- Greater recognition of the individual and collective needs of young people with mental illness.
- A commitment to developing strength based support systems that are flexible to the needs of young people with mental illness.
- Improved workforce development of mainstream and specialised staff is needed to provide better coordinated support and capacity to support young people with mental illness achieve their vocational goals.

2. INTRODUCTION

Since 2012, the National Mental Health Commission (NMHC) has produced an annual Report Card on Mental Health and Suicide Prevention. In this year's Report Card, the chapter *Something Meaningful To Do, Something To Look Forward To* has its topic as "Transitioning from education to independence". This topic will focus on the issues of young people with a mental illness in their transition from education into the workplace. It is planned to address the specific set of circumstances encountered as young people complete their education and then move into meaningful work. It will look at the support available across the education journey and to transition into and secure employment. It will also look at the role of education facilities and employers, support available and inclusive approaches to families/supporters to optimise education and employment outcomes for the individual concerned.

It will focus upon the 15 to 24 years age group, but will also recognise that opportunities for education and employment are also lifelong issues for people living with a mental illness.

This literature review was commissioned by the NMHC to inform and support this endeavour.

Literature Review Methodology

Due to the limited timeframe and the broad scope of the review, a rapid scan informed by key informant consultations rather than a systematic review was undertaken.

The literature review project comprised two phases:

- A literature search: A literature search was conducted to identify the available research, reports, assessments and evaluations relevant to informing and improving the support of young people with a mental illness in their transition from education into the workplace. The focus was on the 15 to 24 years age group, with recognition that opportunities for education and employment are also lifelong issues for people living with a mental illness. The literature search will include both peer reviewed and 'grey' literature from Australian and international sources. Feedback from the key informant consultation phase was incorporated into the literature search.

- Key Informant consultation: Key Informants who are prominent experts in relevant fields, in Australia and internationally, were contacted via email and invited to assist in identifying existing key research, contentions, gaps and priorities in the area.

3. YOUTH TRANSITIONS

For many young Australians, adolescence is a stormy time. From a developmental perspective, young people are in the process of forming their identity including trying out different school, post-school work and study options. Youth transitions involve young people (aged 15 to 24 years) moving between school, post-school study and employment. Numerous factors can influence this time for young people, some of which may derail or prolong their transition from childhood to adulthood. For around half of all young people, this transition remains relatively straightforward (Furlong, 2009). However, for others, it does not go smoothly and may often involve periods of unemployment, involuntary part-time employment, work for fewer hours (under-employment) than they would prefer (Foundation for Young Australians, 2013), or work in low-paid, low-skilled jobs with limited prospects for progression. For a majority of affected young people this is only a temporary state, but for others it persists, and can have long-term consequences. Early experiences of unemployment or weak labour market attachment have been found to increase the likelihood of subsequent and continuing periods without paid work (Sweet, 2012a).

This report focuses on young people aged 15-24 living with or at risk of mental health issues and their transition from school to work. Young people's successful transitions from school to education to employment have long been a source of concern for those responsible for ensuring their safe development to adulthood. The consequence of mental illness can be particularly problematic for this group, and impact on a range of domains within their lives. Young people with mental illness are at a higher risk of having associated problems, including homelessness and/or unstable accommodation, substance use, low academic achievement, unemployment and family breakdown (Zimmermann et al., 2013).

Concern about this group and their trajectory into adulthood has seen an increase in the literature and reports focusing on assessing risk-factors and measuring indicators. The terminology used to represent this group of young people is correspondingly broad, encompassing socially excluded youth, at-risk, vulnerable or marginalised young people as well as 'not in employment, education or training' (NEET) or disengaged youth. All of these concepts have a slightly different focus and all are potentially problematic (Lumby, 2012).

Some researchers caution against labelling young people as being 'at risk'. It has been argued that the focus on the shortcomings or vulnerabilities of young people leads to a deficiency model (Bond, 2010). A counter-narrative presents youth as fundamentally their own agent and resilient, capable of moderating and overcoming the hazards perceived by adults with the appropriate support. This strengths-based approach highlights the capabilities of young people without negating that young people who hit road-blocks need guidance and support to build up resilience. Bond argues that the deficit approach treats young people as 'at risk', which leads to their issues being conceived as 'problems'. In contrast a capabilities or strengths-based approach views the individual young person as part of the solution rather than a problem (Bond, 2010).

There are different ways of measuring success and people take different trajectories. A narrow focus on employment and economic productivity potentially neglects a broader view of a young person's wellbeing and human potential (Bond, 2010). It is important to keep in mind that just because there have been stumbling blocks and delays for individuals, the opportunity to lead a fulfilling life and get back on track does not need to be considered as 'missed'. Successful transitions can take different paths and come in different forms for some young people. Ideally, youth policy and youth services should be guided by a concern for the achievement of human potential and the full expression of capabilities, enabling young people to participate fully in society in a way that is meaningful to them. Furthermore, the narrow focus on instrumental or economic outcomes is potentially blind to the mental health issues experienced by young people supposedly on a 'successful' path. Mental health issues can affect all young people and do not merely show themselves as a failure in transitioning into an economic independent adult.

The theoretical terrain that concerns risk and transitions for young people, and the policies made in response, is extensive. Literature on the concepts of transitions, disengagement, young people, mental health issues and wellbeing seek to identify the interrelated factors in young people's personal circumstances, education, broader network and welfare institutions

which enable schooling to be a positive experience with beneficial academic and affective outcomes.

At the foundation of all youth programs and policies, assumptions are made about young people. The way in which young people are defined and understood shapes the policy responses aimed at addressing their concerns and ultimately guides the services that young people receive.

3.1. METAPHORS OF YOUTH TRANSITIONS: PATHWAYS, TRAJECTORIES OR ROUTES

The metaphors for young people's transition from school to work or further education and training have changed significantly over time. In the 1960s, research on the transition from child to adult was underpinned by psychological understandings of child development and influenced by the work of Erikson (1968) on developmental stages throughout life. This school of thought tended to conceptualise youth as a route to adulthood filled with dangers and threats as opposed to a period in its own right. Youth was a period that, if navigated effectively would lead to the successful accomplishment of a developmental project (becoming adult) resulting in the establishment of a vocational identity (Furlong, 2009). Eventually these routes from dependent child to successful adult would culminate in full-time employment, marriage and home ownership.

With the rise in youth unemployment in the 1970s, these more or less assured routes became more complex and less straightforward leading to the establishment of the concept of 'pathways' as a way of understanding this transition. This shift in thinking was strongly influenced by sociology and reflected a move that placed less emphasis on individuals' subjective orientation and began to focus more on the structures of opportunity available in society.

'Trajectory' became the predominant metaphor in the 1980s as our understandings of the transition from school to work as less than straightforward continued to develop. As unemployment continued to rise, transitions became increasingly intricate and protracted. The concept of trajectory involves the notion that transitional outcomes are strongly conditioned by factors such as social class and cultural capital, and as a consequence largely beyond individual control.

Structural explanations became unfashionable in the 1990s. During this time the focus was on the agency of the individual and the idea of 'navigation' was born. In this, instead of a focus on structural constraints, transitional outcomes were linked to individual factors such as judgement, resilience and life management skills (Furlong, 2009).

An understanding of modern transitions as biographical projects was an idea introduced by du Bois-Reymond (1998). This body of research argues that there has been a shift away from 'normal biographies' (regarded as structured and linear) to 'choice biographies' seen as fragmented and driven by the active choices young people make. In this understanding, young people are increasingly seen as active and engaged agents. Although the scope to construct choice biographies is ultimately shaped by factors, such as class, gender, health and race, structural factors are understood as secondary to agency. Biographical approaches are a useful way of understanding "how individuals make sense of their lives within the dynamic processes of transition and change and embedded within a set of circumstances that they may be unable to control or influence… Biographies are lived out within structures that constrain action and involve contexts where resources are linked to opportunity."(Furlong, 2009, p. 344)

As can be seen in the above, understandings of youth transitions are as much affected by objective changes in the experiences of young people, driven by labour market conditions, institutional arrangements and norms relating to engagement with education and training as they are by theoretical fashion and ideology. Youth transitions research has shifted over time and taken up new frameworks and terminologies in seeking to comprehend these phenomena. As Wyn and Dwyer argue:

> *"The evidence suggests that the life experience and future prospects of this generation are more complex and less predictable than those of their predecessors, and that consequently the established linear models of transition to adulthood and future careers are increasingly inappropriate… This convergence of evidence from different countries and continents points to a need to re-examine established understandings of 'transitions' and the frameworks which have been adopted in much youth research in the past."* (Wyn and Dwyer, 1999, p. 5)

It has been argued that youth researchers have a tendency to either over-emphasise the permanence of deep-seated structural influences or to over-emphasise the disturbance and changes in young people's lives (Evans, 2002). Furlong suggests that although social, historical and structural changes have taken place, providing more choice and agency to young people today, social class is still relevant in the lives of young people as class serves as a frame of reference which conditions behaviour.

> *"While the language of class may be unfashionable, and while class consciousness might be weak, young people frequently have a broad awareness of the extent to which economic and cultural resources impact on their life chances. The challenge for youth research over the coming decades is to draw on our rich understandings of young people's lives in order to re-conceptualise social class in ways that find greater resonance with the complexity of modern lives."* (Furlong, 2009, p. 351).

3.2. TERMINOLOGY

3.2.1. DISENGAGED YOUTH

The terminology used for young people disengaged or at risk of becoming disengaged from education, training or employment is wide. The most commonly used term in Australian policy to describe youth whose educational outcomes are considered too low is 'at-risk'. This term tends to be used to refer to individuals at risk of not completing senior secondary education. Anlezark (2011) cautions against labelling young people as 'at risk' as this can be stigmatising, sorting winners from losers, leading to further exclusion. Te Riele (2006) goes on to argue that labelling individuals at-risk is too simplistic as it heavily focuses on young peoples' personal attributes, neglecting the complex interactions between individual and family circumstances as well as characteristics of schools and society. The author suggests the alternative term 'marginalised young people' arguing that this term "identifies individuals not through their personal characteristics but through their relationship with schooling. This approach allows recognition that marginalisation is at least in part a product of schools and society, and requires action in those arenas" (Te Riele, 2006, p. 129). The same could be argued for the term 'disengaged youth'. This term does not identify the individuals on the basis of personal attributes but focuses on the relationship between the individual and (mainstream) education and employment.

Some researchers prefer the term NEET (not in employment, education or training), while others argue that this exclusively defines young people from what they are not. This term NEET is predominantly used in quantitative studies, replacing the previous focus on youth unemployment. This is a useful term when compared to a focus on youth unemployment as it highlights that an increase in employment levels does not necessarily equals a reduction in vulnerable youth. NEET highlights patterns of vulnerability even at times where youth unemployment, the traditional measure of vulnerability, is declining (Furlong 2006). Many argue that the term NEET is too wide as it combines groups of individuals with very different experiences, characteristics and needs into a homogenous category. It combines young people who are long-term unemployed, experience transient unemployment, provide care to children or relatives, are temporarily sick or long-term disabled, experience mental health issues as well as individuals pursuing an artistic or musical career or simply travelling or taking a short break from work or education. The NEET category aggregates young people experiencing very little or no personal control over their situation with those exercising choice. As a consequence, young people living with mental health issues requiring support and distinct forms of policy intervention are pooled with youth who may not require any support to move back into education or employment.

Others highlight that the term is too narrow and fails to capture the vulnerabilities of individuals who occupy short-term and insecure positions in the labour market:

> *"At the same time we need to recognize that the dichotomy between employment and unemployment is perhaps not well suited to a modern age in which large numbers of people, especially young people, may occupy precarious positions in the labour market and be churned between short-term insecure jobs without experiencing long-term unemployment. The focus on NEET, like the focus on unemployment, draws attention away from those trapped in inferior forms of employment"* (Furlong, 2006, p. 555).

Overall, 'at-risk' captures three common categories (Anlezark, 2011);

- Disengaged youth: young people who are not engaged in full-time education or full-time employment. The annual *How young people are faring* report series uses this definition as an indication of an unsuccessful school-to-work transition.

- Unemployed youth: young people who are out of work and actively looking for work. This definition includes full-time students who are actively looking for work but does not include young people with mental health issues who are currently not looking for work or on a disability pension.

- Young people who do not complete their senior secondary education: also labelled Year 12 non-completers. The relevance of Year 12 completion or its vocational equivalence lies in the fact that this is increasingly considered the minimal education level for preparing youth for the first stages of their post-school life, whether this is further study or employment.

The previous sections have outlined some of the dilemmas in using the term youth 'at risk' as well as 'NEET.' Where one category can be criticised for the heavy focus on the shortcomings of the individual, the latter category does not sufficiently account for individual experiences such as young people with mental health issues. In this debate, a term is required that is less negative and more inclusive - a term narrower than NEET but also capable of adopting a broader definition providing a basis for far-reaching as well as targeted interventions.

Although not completely unproblematic, the term 'disengaged' or 'disengaging youth' will be adopted, where appropriate, to include young people who are currently struggling with the transition from school to work or further education as well as those young people seemingly on a successful path but who are living with mental health issues and in need of special support in order to stay on their chosen path. However, this does not always reflect the focus of the literature being reviewed, so the terminology of the literature will be used if it is more accurate, for example, the term NEET will be used to report on the literature that has used that definition for its findings.

4. HOW ARE OUR YOUTH FARING?

The data presented below provides an overview of how young people are faring, with a focus on prevalence of mental illness and issues such as education completion and employment. However, the relative paucity of data on the mental health of young people reflects Australia's poorly developed system of accountability (Hickie et al., 2005). There is no regular survey or data collection process. The picture of young people's mental health must be pieced together from a range of data sources.

4.1. MENTAL HEALTH AND DISTRESS

The National Survey of Mental Health and Wellbeing (ABS, 2008a) was conducted in 1997 and 2007 and involved 8,841 households of over 16 year-olds found that young people were more likely to have a mental disorder compared to those who were older.

The Australian Institute of Health and Welfare (AIHW, 2011) reported that in 2007, among young people aged 16–24 years:

- *"An estimated one in four young people (26%, or 671,100) experienced at least one mental disorder in the preceding 12 months."*
- *"Females were more likely than males to have experienced mental disorders (30% and 23% respectively)."*
- *"Overall, the most commonly reported disorders were anxiety disorders (15%), substance use disorders (13%) and affective disorders (6%). While this pattern held true for females (22%, 10% and 8% respectively), among males substance use disorders were more prevalent than anxiety disorders (16% compared with 9% respectively)."*
- *"The prevalence of affective disorders was considerably lower among males than females (4% and 8% respectively)."*
- *"The most prevalent types of anxiety disorders were post-traumatic stress disorder and social phobia, accounting for 50% and 35% of anxiety disorders, respectively."*
- *"Harmful use of alcohol was the most common substance use disorder, accounting for almost one-third of substance use disorders."*
- *"The leading causes of hospital separation for mental and behavioural disorders among young people aged 12-24 years in 2008-09 were: mood disorders (24% of mental and behavioural disorder separations), such as depressive disorders; mental and behavioural disorders due to psychoactive substance use (19%); neurotic, stress-related and somatoform disorders (18%), such as anxiety disorders and adjustment disorders."*

Young people are also less likely to seek help for mental disorders compared to those aged 25 years and over. For example, 23% of those aged 16–24 years with a 12-month mental disorder accessed health services in the preceding 12 months, compared with 38% for those aged 25 years and over. Of those young people who sought help, most sought help from general practitioners (63%) followed by psychologists (43%). (AIHW, 2011)

It is also important to note that there was a greater prevalence of high or very high levels psychological distress reported by young people living in areas of lowest socioeconomic status (SES) (13%) compared with those living in the highest SES areas (9%). In comparison, 22% of young people in the lowest SES areas reported having a mental disorder compared to 26% in highest SES areas. However, "there were no significant differences in the prevalence of high or very high levels of psychological distress or mental disorders among 16-24 year olds" (AIHW, 2011, p. 28).

AIHW highlight there are many gaps in our understanding of mental health among young males, especially among certain groups such as young males in more remote geographic locations or those who are detained in prison.

4.2. ONSET OF MENTAL HEALTH DISORDERS

McGorry et. al (2011) conducted a review of studies on the age of onset of major mental illness and found that:

> *"Most disorders emerge prior to the age of 25 years, through a cascade of stages with initial clinical syndromes resolving, evolving or collecting additional dimensions, often termed 'co morbidity'"* (p. 302)

A review conducted by de Girolamo et al. (2012) on the age of onset (AOO) of major mental disorders found that:

- *"Although the behaviour disorders and specific anxiety disorders emerge during childhood, most of the high-prevalence disorders (mood, anxiety and substance use) emerge during adolescence and early adulthood, as do the psychotic disorders. Early AOO has been shown to be associated with a longer duration of untreated illness, and poorer clinical and functional outcomes."*

- *"Epidemiological studies consistently indicate that anxiety disorders are among the most prevalent mental disorders among children, with cross-sectional studies showing that up to 20% of paediatric patients score above the identified clinical cut-offs for one or more anxiety disorders (Rockhill et al. 2010). Anxiety disorders have relatively equal prevalence rates among young boys and girls, but then become more common in females, with a 2:1–3:1 female preponderance by adolescence (Rockhill et al. 2010)."*

- *"In general, while some anxiety disorders have a median AOO within childhood (particularly specific phobias and separation anxiety), most of the high prevalence anxiety disorders typically emerge during early adolescence and early adulthood… Adolescent onset of anxiety disorders is also associated with more severe and disabling forms of these illnesses (Paus et al. 2008)."*

- *"Several studies have examined correlations between the AOO of depression and the course or nature of illness, with an earlier onset associated with more chronic illness (Angst et al. 2009), a greater number of depressive episodes among females, but not males (Essau et al. 2010) and longer episode duration, increased suicidality and need for hospitalization (Korczak & Goldstein, 2009). In the large sample (N = 89 037) of the WMH Survey Initiative, data from 18 countries were analysed and the average AOO, ascertained retrospectively, was 25.7 in the high- income and 24.0 in low- to middle-income countries. The female:male ratio was about 2:1, and in high-income countries, younger age was associated with higher 12-month prevalence (Bromet et al. 2011)."*

The information regarding the AOO for schizophrenia are mixed. De Girolamo et al. (2012) note that "…studies that cover most of an individual's life span suggest that the median AOO of schizophrenia for males is in the late 20s and for females is in the mid-30s" (p.50). However, other studies have found earlier AOO, for example, in the WHO multinational DOSMED study (Jablensky et al., 1992), 70% of male patients and almost 60% of female patients had illness onset before 25 years of age. De Girolamo el al. also found evidence to support early intervention, including one study where individuals with an early onset who received early intervention and treatment had significantly fewer positive symptoms and significantly superior functioning on measures assessing global, social/occupational and community functioning compared to patients with adult-onset disorder, equally treated (Amminger et al., 2011). However, research showed that there were often long delays in making treatment contact and significant between-country variation. De Girolamo et al. highlight the WMH Survey Initiative's findings that the delay among those who eventually made treatment contact was significant, ranging from 6 to 8 years for mood disorders and 9–23 years for anxiety disorders. De Girolamo et al. found a high level of continuity between childhood/adolescent and adult psychopathology.

4.3. TRANSITIONS AND MENTAL HEALTH

In 2010, it was reported that 10% of school leavers aged 15-24 years were unemployed and not enrolled at a non-school institution with a further 8% not in the labour force and not enrolled at a

non-school institution (ABS, 2010, p. 5). There were high unemployment rates among 15-24 year olds living outside capital cities (13.0%) than for those in capital cities (9.2%) (AIHW, 2011, p. 135).

The research consistently shows that young people with mental illness face greater participation challenges in employment and education. For example, an investigation conducted for the Inspire Foundation by Degney et al. (2012, p. 6) found that "young men with mental illness have much lower rates of educational attainment compared to their peers, further limiting their skills development and long term reduced earning potential by $559 million per year". LaPlagne (2007) asserted that out of six major health conditions (Cancer, Cardiovascular disease, Mental/nervous condition, Major injury, Diabetes, Arthritis), averting a mental health or nervous condition has the largest positive impact on labour force participation.

Cavallaro et al. note (2005, p. 42) that "only one in eight (12.1%) students with a mental illness completed an Australian Qualifications Framework (AQF) qualification in 2003. This is the lowest award rate of all the major disability groups and considerably lower than that for the total VET population (18.0%)." Likewise, "Attrition from VET courses occurs at a greater rate among people with a mental health condition, who report that they are often unable to access help from others." (Polidano & Mavromaras, 2010: 3). Those who have other disabilities in addition to mental illness, face greater challenges to participation in education (Cavallaro et al.).

5. DISENGAGEMENT FROM EDUCATION AND EMPLOYMENT

5.1. WHY IS DISENGAGEMENT FROM EDUCATION AND EMPLOYMENT A PROBLEM?

A prime area of concern for policy makers in the OECD has been the increasing numbers of young people who are not in employment, education or training, given the acceptance in the literature that there are associations between NEET status and possible disadvantage later in life.

5.1.1. INDIVIDUAL COSTS OF NEET

NEET status in adolescence and young adulthood has been associated with a range of adverse consequences and social disadvantage later in life, including:

- Mental and physical health problems;
- Higher stress;
- Substance use;
- Lower lifetime satisfaction;
- Teenage pregnancy and earlier parenting;
- Persistent youth offending;
- Higher personal discount rate (i.e., the tendency to value money in the present far greater than money in the future, and thus being less willing to invest);
- Less risk aversion;
- Insecure housing and homelessness;
- Residing in poorer neighbourhoods;
- Earlier death. (Coles et al., 2002; CEDEFOP 2010; Coles et al., 2010)

In addition to these negative outcomes, NEET status also has serious consequences for an individual's future employment.

5.1.2. FUTURE EMPLOYMENT

NEET status is associated with a higher incidence of unemployment, and longer durations of unemployment (Brader & McGinty, 2005) In fact, it has been argued that the primary predictor of NEET status in adulthood is NEET in adolescence (Coles et al., 2002). Evidence to support this comes from a 2010 analysis of British longitudinal survey data which found individuals' education and transition status at age 16-18 years to be associated with particular labour market outcomes (Crawford et al., 2011).

The initial transition status of an individual at the age of 16/17 was found to be highly correlated with their status in subsequent years. Around half the young people who were NEET at age 16/17 were NEET one year later. Likewise, around half of those who were NEET at age 17/18 were still NEET at age 18/19. In addition, an initial period of NEET status between the ages of 16 to 19 is linked to a greater risk of periods of worklessness in the medium term.

The analysis also revealed that the longer the duration of NEET status, the higher the risk of poor employment outcomes. Those who remained NEET between the ages of 16-19 were far more likely to be unemployed in the long term.

This persistence in NEET status has particular implications for early school leavers who find themselves in this position. These individuals have a high risk of being unemployed not only in the two years following their cessation of education, but also in 5 years time, and 10 years time.

There is also persistence in employment status, with 59% of those in a job without training and 71% of those in a job with training at age 16/17 were still employed in the same type of job one year later.

Early school leavers who become NEET initially are more likely to gain employment in a job without training. However, being NEET between the ages of 16-19 was associated with poorer employment outcomes (both short term and long term) than being in a job without training (or any other activity state).

5.1.3. SCARRING EFFECTS AND WAGE PENALTIES

The persistence of NEET status and its detrimental effect upon future employment outcomes have been referred to as "scarring effects" (Mascherini et al., 2012). According to the OECD, young people with mental disorders are even more vulnerable to scarring effects (OECD, 2011).

The findings regarding scarring and wage penalties indicate that NEET is not a temporary problem. The evidence has shown that NEET can have negative consequences even beyond the age of 30.

Given the long-term employment consequences of NEET, and the fact that employment is a crucial determinant of wellbeing, protracted periods of NEET early in life may have important long-term implications for mental health. Continuing a trend over recent years, the proportion of Disability Support Pension recipients with a psychological/psychiatric primary medical condition (29.5%) surpassed musculo-skeletal and connective tissue (28.2%) for the first time in 2011 (FaHCSIA, 2011, p. 5). This group has been growing in number by an annual average of 5% since 2001, at more than twice the rate of overall growth in DSP recipients (DOHA, 2010, p18).

The Australian National Mental Health Reform was initiated on the basis that an early intervention approach to mental health can lead to substantial cost savings in the long-term. Similarly, the evidence presented here suggests that early intervention for NEET is critical in order to prevent scarring effects and the public cost of long-term unemployment and welfare dependency. The biggest predictor of long term NEET status, is early NEET status. Early intervention applied to both mental health and NEET is likely to (a) reduce economic costs (b) prevent progression into more severe mental disorders, and (c) decrease the likelihood of long-term employment or NEET.

5.2. WHAT LEADS TO DISENGAGEMENT FOR YOUNG PEOPLE?

The 2011 Australian Bureau of Statistics Survey of Education and Work found that 19% of people aged 15 to 24 years were not engaged in education, training or employment. Of these 47% did not complete Year 12 and were not currently undertaking a non-school qualification.

There is no single defining set of characteristics of young people who are, or at risk of becoming, disengaged. The reasons behind disengagement by young people are varied and complex. In general, research focusing on the causes behind school disengagement can be grouped into two broad categories: a) personal and/or family related, and b) the inability of the conventional educational system to cater for a diverse range of learning styles (Butler et al. 2005).

Research that focuses on personal and or family related hardship as the principal cause of disengagement highlights a lack of opportunity for community involvement, financial pressures, lack of transportation, low parental engagement with schooling, family poverty, violence and abuse, families with physical and mental illnesses and/or drug and alcohol problems, low levels of literacy and behavioural problems (Butler et al. 2005).

The lack of capacity of mainstream educational institutions to cater for students' diverse

learning styles is highlighted by many researchers (Myconos, 2011; Butler et al., 2005; Bond, 2010). This body of research suggests that some of the reasons young people disengage from school are associated with a lack of understanding of alternative learning temperaments. Traditional methods of pedagogy, offer little or no acknowledgement to different forms of learning styles such as kinesthetic and experiential methods, which have been found to be the preferred ways of learning for students labeled 'at risk'. Furthermore, these students often experience problematic relationships with teachers, have problems abiding to school rules, experience a lack of perceived relevance and success in academic programs, all of which can complicate the students' integration into school environments. As a consequence of a perceived negative school environment, many students disengage from school due to negative 'push' factors, rather than being 'pulled' to a positive alternative to post-compulsory schooling. The undesirable school culture "can manifest in a non-stimulating environment with no discernible relationship to the wider community or adult world, a lack of support and referral agencies to help young people cope with personal and academic hardship, and negative student–teacher relationships" (Myconos, 2011, p. 9). This aspect is of importance as it emphasises the structural and educational constraints, including the underlying pedagogy and structure of mainstream education involved in youth disengagement along with the individual's 'at risk' attributes.

Myconos goes on to argue that labeling students 'at risk' potentially masks the actual causes of their disengagement, for example, not responding positively to traditional modes of learning as opposed to reconsidering the teaching style utilised (Myconos, 2011). This misplaced labeling can often lead to a situation where the students themselves attribute their problems to personal deficits (being lazy, unintelligent, lacking motivation etc.) as perceived by others. It is important to acknowledge that teachers in mainstream school settings work in the context of large classes, high curriculum demands and the pressure to produce quantifiable learning outcomes leaving few resources available for investment in working with disengaged or troublesome students. Some suggest a shift towards a more holistic approach to teaching and learning is required in order to re-integrate disengaged young people into mainstream education – as well as to not marginalise these individuals in the first place.

Recent European reviews conducted by the European Foundation for the Improvement of Living and Working Conditions (2011) found the following factors connected with an increased probability of youth disengagement: disability including mental health concerns; coming from an migrant background; low educational attainment; living in remote areas; coming from a low low SES household; and having parents who are divorced. The majority of these factors are cumulative. The review goes on to highlight the importance of flexible policies and programs which are capable of addressing the needs of a very heterogenous group.

The likelihood that a young person will become disengaged is associated with a complex interaction of individual, institutional and economic factors. Anlezark has summarised these factors, distinguishing between exogenous factors (those factors over which the individual has little or no control) and mediating factors (understood as those factors where individuals experience some degree of choice) (Anlezark, 2011, p.6).

Exogenous factors	Mediating factors
• Indigenous	• Poor attitudes to school
• Born in Australia	• Attend government school*
• Live outside metropolitan areas	• Poor student–teacher relationship
• Low academic achievers	• Dislike of school
• Low levels of literacy and numeracy	• Intention in Year 9 to leave school early
• Low socioeconomic status	• Poor student behaviour
• Parents work in blue-collar occupations	• Lack of engagement with school extracurricular activities

• Parents without university education
• Non-nuclear family

* Note: May also be an exogenous factor if limited school choices are available.

Much of the literature on disengaged young people cautions against stereotyping this group of individuals. Young people who are disconnected from the labour market and educational system have a very diverse range of needs as well as personal circumstances. Some disengaged young people, although not all, are up against enormous personal, educational, social, health and economic barriers to participation in employment and education. In this regard Sweet highlights that policy and program responses to disengaged young people should be flexible enough to allow both prescriptions for young people's behaviour and forms of assistance to suit individual needs and circumstances.

What we do know about inactive youth is that around half of all 15-19 year-olds are recipients of welfare benefits, predominantly disability support pensions (30%) and parenting payments (18%) (Sweet, 2012).

The diversity of disengaged young people's circumstances, means that the barriers to re-engagement are equally as broad, as found in a survey of 22,171 disengaged young people over the 1 January 2010 to 30 September 2012 period (DEEWR, 2011). These young people were all participants in the Youth Connections program who had been disconnected from education for longer than three months. The most common barriers identified were low self esteem, poor basic educational skills, lack of social skills and behavioural issues, financial constrains and lack of family support. Mental health problems were identified by over 30% of the participants. Importantly a high proportion of these young people experienced multiple barriers to re-engagement as shown in the Table below:

Identified barriers to participation among level Youth Connections clients (%)

Barrier	%
Low self esteem	56%
Low literacy or numeracy	52%
Socialisation issues	44%
Financial distress	42%
Behavioural problems	41%
Inadequate family support	36%
Suspected or diagnosed mental health issue	32%
Anger management issues	28%
Alcohol or drug misuse	26%
Unstable living arrangements	26%
Bullying	21%
Critical life event	18%
Current or previous juvenile justice orders	17%
Abuse or Domestic Violence issue	12%
Medical or other health issue	12%
Negative experience with education and training	12%
Homelessness	8%
Learning Difficulty	8%
Parent/Pregnancy	7%

Disability	5%
Disconnection from cultural heritage	5%
In detention/previously in detention	5%
Out of home care	5%
Young Carer responsibilities	4%
Gifted	1%
Volatile substance misuse	1%

Source: DEEWR (2011) Youth Connections Program Report, 1 January 2101 to 30 September 2012. In Sweet 2012

Despite these barriers and risk factors, Myconos stresses the importance of remembering that "the relationships between risk factors and educational outcomes are too complex and not yet fully understood" (Myconos, 2011). There is no "typical" school leaver, as a variety of factors and attitudes can cause disengagement from school. Although the research is divided in regards to the relative importance of personal and structural factors, most in this research field agree that disengagement from school is a process involving numerous factors in the context of the family, the school and wider community contexts, and cannot be attributed to one particular event or factor. Conversely, mental health issues do not necessarily lead to a protracted transition or disengagement.

Overall the commonly identified risk factors fall into one of three categories:

- **individual factors**, e.g. poor self-esteem, mental health issues, low intelligence, school non-attendance

- **contextual factors**, e.g. family factors, parental illness, ethnicity, low socioeconomic status, neighbourhood or regional characteristics

- **institutional factors**, e.g. school environment, job network and other welfare institution.

In order to keep individuals on successful pathways in a way that is meaningful and offers optimal levels of support to young people who have disengaged, policies and services need to consider all three categories of factors. Services that focus on addressing individual factors will not only be less effective, they may lead to a worsening of the situation for some young people by further stigmatising them through the sole focus on deficits. As mentioned earlier, the tendency to focus on young peoples' shortcomings may result in detrimental self-blaming.

5.3. LINKS BETWEEN DISENGAGEMENT AND MENTAL ILLNESS

Many studies have identified a negative association between mental illness in young people and engagement in education or employment (Fergusson et al., 2001; Waghorn et al., 2012; Breslau et al., 2011; Lee et al., 2009) Those young people who find themselves not only NEET, but also psychologically unwell, face significant barriers to employment. According to the OECD, young people with mental illness have a double disadvantage in the labour market (OECD, 2011). In addition to the barriers to employment posed by their mental health, the unemployment rate is highest for young people, rendering them less competitive in the labour market by virtue of their age.

Additionally, the OECD argues that unmet needs for mental health services may result in early school leaving (OECD, 2011). Surveys in Sweden have demonstrated that mental illness is a primary reason for leaving school early. Other important reasons for dropout were:

> *"... further related to mental health and wellbeing; for instance, bullying and school stress. Moreover, it has been found that while many early school leavers eventually earn a*

diploma, young people with mental health problems have an increased risk of never earning secondary qualifications" (Wyckoff et al., 2008)

Poor mental health is associated with NEET status even when controlling for social disadvantage (a key predictor of NEET) (Benjet et al., 2012). Benjet et al. argued that this finding implicates mental health as a key factor in successful school to work transitions. Following on from this finding, an important question is whether mental health is a cause or a consequence of NEET. Whether disengagement from education and employment is precipitated by pre-existing psychopathology, or whether it increases the risk of mental illness through failing to meet needs and provide appropriate social scaffolding is the subject of the next two sections.

5.3.1. DISENGAGEMENT AS A CONSEQUENCE OF MENTAL ILLNESS

There is an abundance of evidence to suggest that mental illness predicts or precedes NEET status and educational disengagement. Data from the Longitudinal Study of Young People in England was analysed to find that poor mental health was associated with GCSE examination performance at age 16, and also associated with an increased probability of being NEET at age 17/18 (Cornaglia et al., 2012). Specifically, poor mental health increased the probability of NEET by 2.7% for young females and 3.3% for young males after controlling for other factors. This association was high given the overall NEET rates of 7.6% for females and 10.6% for males in the sample. Furthermore, the strength of this association was not significantly impacted by controlling for exam performance at age 16, suggesting that mental health does not affect NEET outcomes via its impact on exam performance. In other words, young people with mental health problems who become NEET experience other barriers to engagement beyond impaired performance.

In an analysis of Australian survey data, the earning and learning of adults with schizophrenia, depression and anxiety was compared to that of adults with non-psychiatric disabilities and healthy adults (Wagnorn et al., 2011). Twice as many healthy adults completed post-secondary education, than those with schizophrenia, or mental disorders other than depression and anxiety. Importantly, those with non-psychiatric disabilities were about as likely to have completed post-secondary education as healthy adults. This suggests that the experience of mental illness can negatively impact outcomes more so than other health conditions and present additional barriers to work and study that are not currently being supported by organisations or the education system.

Waghorn (2011) argues that educational institutions ought to do more to facilitate students with mental illness considering that: (1) knowledge about best practice educational support for people with psychiatric disorders is available, and (2) people with education goals can successfully obtain all types of post-secondary qualifications, even those with severe mental illness.

An American longitudinal study found that depressive symptoms experienced during high school were negatively related to educational outcomes (i.e., withdrawal from high school, college enrolment, college type) (Fletcher, 2008). However, this relationship was observed only in females. The authors concluded that improvements in the diagnosis and treatment of depression in young people may be needed to mitigate the negative relationship between adolescent depression and educational attainment.

Using Australian national survey data, Leach and Butterworth (2012) found that adolescent affective, anxiety, and substance use disorders are associated with early school leaving. For males, dropout prior to completion of Year 10 was associated with having experienced any mental disorder, particularly any early onset (i.e. <16 years of age) affective disorder and any substance use disorder. Young women with substance use disorders and episodes of depression were less likely to complete Year 10. The authors noted that early onset mental disorders have a strong impact on minimum school completion, despite Australia's high education completion rates and strong policy focus on educational attainment.

5.3.2. MENTAL ILLNESS AS A CONSEQUENCE OF DISENGAGEMENT

While there is strong longitudinal evidence indicating that mental health precedes NEET status, there is less evidence that mental illness is a consequence of NEET status.

Recent OECD panel data has been used in an attempt to establish a causal relationship between mental health and changes in employment status:

> *"The results show that moving from employment to unemployment or inactivity has a large, negative impact on mental health, with a larger impact on men than women … Both situations increase distress by more than any other life changes such as accidents or loss of partner. In Australia, the United Kingdom and Switzerland, a change from employment to sickness-related inactivity results in the worst effect on psychological distress; with the second largest negative change being a transition from employment to unemployment. Finally, results generally show that when people's status changes from non-employment to employment, their mental health improves."* (OECD, 2011)

In addition, it is generally accepted that mental illness hampers school performance, rather than it being school stress that contributes towards mental illness (Waghorn, et al., 2011). While there is less evidence for the predictive impact of NEET status upon mental health, the relationship between these two variables appears to be bidirectional.

5.3.3. EXAMINING NEET CHARACTERISTICS IN A YOUTH MENTAL HEALTH SAMPLE

Regardless of the direction of causality, the literature does indicate that NEET youth have a greater mental health risk. Despite this, research is yet to determine the key factors that increase risk. As stated, the lack of an effective framework for accountability in mental health limits our understanding to data collected from the relatively few young people with a mental illness who do seek care. We know even less about those that are not in care. Nevertheless, in a recent attempt to explore such factors, researchers at the Brain and Mind Research Institute investigated the characteristics of NEET status among a sample of 15-25 year olds seeking help for mental health problems at Headspace (manuscript in preparation). This study aimed to identify the factors that distinguish young people with mental illness who are NEET from those who manage to remain in employment or education.

The data from the Brain and Mind Research Institute indicated that among young people seeking help for mental health, NEET status is primarily associated with depressive symptoms in males. For females, psychological symptoms per se were not associated with NEET, however severity and chronicity (i.e. clinical stage) of the mental illness were. Young help-seeking females were also more likely to be NEET if they used cannabis regularly, had ever been charged with a crime, or if they had a child-onset developmental disorder such as ADHD or autism.

The results seem to suggest that different aspects of mental illness may lead to NEET status for males versus females. Since this study was cross-sectional, an alternative explanation may be that NEET status impacts upon males and females differently (e.g., young males may become more depressed in response to their NEET status).

The analysis also revealed that level of educational attainment, a key demographic predictor of NEET, was not associated with NEET in this help-seeking sample. In other words, among young people suffering with mental health problems, those with a university degree are just as likely to be NEET as early school leavers.

This study was the first to examine characteristics of those categorised as NEET in a relatively small clinical sample (approx. 600 individuals). It should be noted that only a small proportion of young people with mental illness seek help (particularly young males). The factors associated with NEET in those who do not seek help may be different. Much more research is needed in this area to gain a clearer picture of the factors leading to NEET status for young people with a mental illness.

The study also found that the prevalence of NEET status in this sample of help-seeking young people was 22%, double the national average (11.4%). Help-seeking young males were three

times more likely to be NEET, placing them at a higher social disadvantage than youths in Spain and Greece, where there is a current economic crisis.

It is important to note that although mental illness creates barriers to education and employment, a sizeable proportion of people experiencing mental illness (particularly common disorders such as depression and anxiety) are employed. OECD data suggests that, on average, the employment rate of people with common mental disorders is about 60-70%. While this is 10-15% lower than the employment rate of people without mental disorders, it is evident that the majority of people with common mental disorders are able to work, albeit often in lower status jobs and for shorter durations. The employment rate for people with severe mental disorders is around 45-55% (OECD, 2011).

5.3.4. SUMMARY

Overall, there is strong longitudinal evidence demonstrating that mental illness disrupts educational attainment and makes a young person less likely to make vital transitions, and hence more likely to become NEET. Furthermore, NEET young people are at a greater mental health risk. As such, they represent a key population for targeted interventions and prevention.

6. CONCEPTUALISING SUPPORT

6.1. DEFICIT OR STRENGTHS-BASED APPROACHES TO SERVICE DELIVERY

There is growing concern amongst researchers studying youth about the 'deficit approach' taken by youth services and policy makers. The deficit approach focuses on the identification and measurement of particular risk factors with the aim to control these perceived risks and thereby avoid undesirable social outcomes (Bond, 2010). It has been argued that the at-risk or deficit approach and corresponding service delivery further stigmatises young people (Bond, 2010) and characterises them according to particular issues that must be solved. This issues include, but are not limited to: teen pregnancy, crime, underage drinking, substance abuse, mental illness, suicide, sexually transmitted disease, early school leaving, unemployment, antisocial behaviour, incarceration.

More recent research has sought to shift this focus to one which considers the structural factors which may affect a young person's ability to engage with education and employment systems. This approach, termed 'ecological' or 'strength-based', is more holistic and focuses on the unmet or unfulfilled needs of the individual, and on the interactions between individual students and their environments (Myconos, 2011). It encompasses a serious consideration of young peoples' social, academic, psychological, and career-related needs and focuses on connectedness, feeling valued, attachment to pro-social institutions, the ability to navigate in multiple cultural contexts, commitment to civic engagement, good conflict resolution and planning for future skills, a sense of personal responsibility, good moral character, self-esteem, confidence in one's personal efficacy, and a sense of a larger purpose in life (Eccles & Gootman, 2002 in Bond, 2010).

The strengths-based approach is based on six key principles:

- Every individual, family, group and community has strengths, and the focus is on these strengths rather than on pathology

- The community is a rich source of resources

- Interventions are based on client self-determination

- Collaboration is central with the practitioner-client relationship as primary and essential

- Outreach is employed as a preferred mode of intervention; and

- All people have the inherent capacity to learn, grow and change (Scerra, 2012).

A review by Kerka (2003) focusing on alternatives for disengaged and out-of-school youth identified eight factors consistently mentioned in research reports and descriptions of effective alternative programs: the presence of caring, knowledgeable adults; a sense of community; resource focused approach to youth; high expectations of academic achievement and accountable behaviour; treating individuals holistically; authentic and engaging learning opportunities that can instil hope; support; and long-term follow-up services.

These findings were supported by Bond (2010) who suggested that universal programs, which bring services into schools rather than pulling out students are preferential to targeted programs which could alienate students from their peers. By delivering flexible and alternative education programs to all students, regardless of mental health status, the stigma associated with receiving services may decrease (Bond 2010).

The capabilities approach, developed by the economist Amartya Sen (2009), is also relevant. This is increasingly used by governments to identify the individual, social and economic resources that are needed to support individual wellbeing, social inclusion and individuals' capacities to make choices about their lives; including how they wish to live, and the work they undertake. This ideology is echoed in the Federal Government's social inclusion policy *A Stronger, Fairer Australia*:

> *"An inclusive Australia is one where all Australians have the capabilities, opportunities, responsibilities and resources to learn, work, connect with others and have a say. In Australia today, not all Australians can do these things. Our social inclusion strategy is about making sure that, over time, every Australian can play an active part in shaping their own life and contributing to the economy and community."* (DPMC, 2009, p.2)

An approach that considers individuals' capabilities fits well with a strengths-based approach to youth wellbeing as it provides a broader frame of reference than economic independence. The focus then shifts towards frameworks that facilitate human flourishing, foster dignity and increase quality of life (Bond, 2010).

6.2. FOCUS ON RECOVERY

The concept of recovery as an important measure of functioning only received attention in the late 1990's largely through evidence that demonstrated that recovery from mental illness and prevention of further episodes after onset was possible (Urbis, 2007).

A focus on recovery is a strength based approach that acknowledges the lived experience of the person with mental illness and their goals (Lloyd, 2010). According to Lloyd (p. 127-8):

> *"Recovery is defined as the process of overcoming symptoms, psychiatric disability and social handicap (Rickwood 2004). It involves a redefinition of the self, the emergence of hope and optimism, empowerment and the establishment of meaningful relationships with others (Resnick et al 2004). Recovery is oriented towards the reconstruction of meaning and purpose in one's life, the performance of valued social roles, the experience of mental health and wellbeing, and increasing life satisfaction. It means maximising wellbeing within the constraints that may be imposed by residual psychiatric symptoms. Best practice incorporates the provision of continuing care, comprising relapse prevention plans and rehabilitation, provided within a recovery orientation…. Recovery-focused rehabilitation interventions typically promote the goals of community integration, improved quality of life, personal empowerment and recovery (Casper et al 2002). Practices that serve these goals and have an underpinning evidence base include individualised supports, consumer choice, skills training, supported employment, supported education, peer support and social network development" (Casper et al 2002)."*

7. RESEARCH ON INTERVENTIONS AND MODELS OF SUPPORT

7.1. PREVENTION AND EARLY INTERVENTION

Prevention is widely recognised as being preferable to intervention. However, it is acknowledged that not all mental health conditions may be preventable and that where intervention is required, the appropriate treatment should start sooner rather than later.

National Research Council and Institute of Medicine (2009) notes that issues in defining prevention have existed since the earliest efforts to incorporate preventative approaches to the field of mental health. Having clear guidelines for what is considered prevention and what is considered treatment is viewed as critical to being able to accurately measure the type and extent of current activities and to limit confusion in intersectoral collaboration.

Two prevention models from public health were adapted for mental health: Caplan's (1964) application of the concepts of primary, secondary, and tertiary prevention; and Gordon's (1983) three-part classification, which distinguished between universal, selective and indication prevention. The latter was adopted and modified by the Institute of Medicine in a 1994 report on *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. There has been some contention in the policy and literature as to whether the definition of prevention should include or exclude the prevention of disease relapse or further disability or co morbidity. National Research Council and Institute of Medicine (2009, p. xiv-xv) stated:

> *"We propose a new emphasis on true prevention, which for the purposes of this report we define as occurring prior to the onset of disorder, as well as mental health promotion, discussed immediately below. We do not disparage society's emphasis on treatment and indeed think that in the domain of mental health, far more resources should be devoted to the effort. Rather, we want to highlight the critical need for a more proactive, preventive focus on mental health….*
>
> *Prevention emphasizes the avoidance of risk factors; promotion strives to promote supportive family, school, and community environments and to identify and imbue in young people protective factors, which are traits that enhance well-being and provide the tools to avoid adverse emotions and behaviors. While research on promotion is limited, emerging interest and involvement in it and the potential it holds for enhancing health warrant its inclusion in the consideration of how the nation can improve its collective well-being."*

While an extensive review of the literature on children and young teenagers is outside of the scope of this report, there is growing evidence that promotion, prevention and early intervention can significantly reduce later life disability and disadvantage. As most mental health disorders have their onset early in life, the evidence suggests that the greatest prevention opportunity is among young people.

In an extensive analysis of the literature, National Research Council and Institute of Medicine (2009) found that:

- *"Evidence that improving family functioning and positive parenting serves as a mediator of positive outcomes and can moderate poverty-related risk.*

- *Emerging evidence that school-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.*

- *Evidence that interventions that target families dealing with such adversities as parental depression and divorce demonstrate efficacy in reducing risk for depression among children and increasing effective parenting.*

- *Evidence from some preventive interventions that benefits exceed costs, with the available evidence strongest for early childhood interventions.*

- *Evidence of interactions between modifiable environmental factors and the expression of genes linked to behaviour.*"

7.1.1. SCHOOLS

In a literature review commissioned by the NSW Department of Education and Communities into meeting the psychological and emotional wellbeing needs of children and young people Urbis (2011), notes that Australia was one of the first countries to adopt the 'health promoting schools' approach recommended by the World Health Organisation (WHO). This approach comprises three overlapping tiers of intervention:

- *"Universal programs aim to develop students' social, emotional and behavioural competencies. Focusing on primary prevention, they including classroom-based approaches, changes to the school environment as a whole and wellbeing programs beyond the school to include the family and community. According to the health promotion model, the greatest amount of time and resources should be spent on these whole-school approaches.*

- *Selected interventions are for students who have been identified as being at risk for developing emotional or behavioural disorders. Use is made of individual and group approaches to help prevent the onset of behaviour or emotional problems.*

- *Targeted interventions are for individual students who have been identified as having an emotional or behavioural problem or a mental health disorder. The focus is on individual treatment and the prevention of further difficulties for students identified as having problems."* (Urbis, 2011)

While Urbis notes that interventions to target wellbeing in children are broad and that programs appeared to be more likely to be effective if they:

- o *are aimed at promoting mental health rather than preventing mental illness*
- o *involve the whole school and include changes to the school's environment*
- o *assist students to develop adaptive, cognitive and behaviour strategies*
- o *involve parents and the wider community*
- o *take into account the age and gender of the children*
- o *are implemented over a long period of time (continuously for more than one year)*
- o *allow for periodic follow-up of positive interventions (also described as 'booster sessions') in order to maintain positive outcomes and counter the evidence that effect sizes (statistical measure of the impacts of interventions on wellbeing outcomes) decrease over time.*

- *Less effective programs or interventions appear to be those that are fear-inducing and those focused on knowledge (delivering information) only.*

- *Selected programs appear to be more effective than universal programs for students who have been identified as being at risk for, or diagnosed with, specific problems, although universal programs have a role in enhancing protective factors which help to build resilience.*

- *For students with depression, selected programs may be more efficacious due to the increased room for change amongst participants with elevated symptoms of depression, and intervention programs consisting of 8 to 12 sessions may be more successful at reducing symptoms than programs which are shorter or longer than this.*

- *Selected programs targeting children and adolescents at risk for violence may be effective, but caution should be adopted in working with such students on a group basis.*

7.1.2. RESILIENCE AND THE ROLE OF FAMILY

According to Davydov et al. (2010, p. 479):

> *"Resilience can be viewed as a defence mechanism, which enables people to thrive in the face of adversity and improving resilience may be an important target for treatment and prophylaxis. Though resilience is a widely-used concept, studies vary substantially in their definition, and measurement. Above all, there is no common underlying theoretical construct to this very heterogeneous research which makes the evaluation and comparison of findings extremely difficult. Furthermore, the varying multi-disciplinary approaches preclude meta-analysis, so that clarification of research in this area must proceed firstly by conceptual unification."*

While the literature on resilience is heterogenous, there is a reoccurring theme of the importance of families in influencing the later life resilience of children. Werner (2012, p.103) in a review of large-scale longitudinal studies conducted in the US, UK, Western Europe, Australia and New Zealand found:

> *"The frequency with which the same predictors of resilience emerge from longitudinal studies conducted with different ethnic groups and in different geographic settings is impressive. In most cases the factors that mitigated the negative effects of childhood adversity also benefited children who lived in stable and secure homes, but they appear to have particular importance when adversity levels are high.*
>
> *Large-scale longitudinal studies have demonstrated that an early history of developmental competence, engendered by consistent and supportive care, is a powerful and enduring influence on children's adaptation at later stages of the life cycle and increases the likelihood that they will rebound from a "troubled" adolescence.*
>
> *The pathways that lead to positive adaptation, despite childhood adversity, are complex, and there is great need to map the interconnections between individual dispositions and outside sources of support that increase competence and self-efficacy, decrease negative chain effects, and open up opportunities, whether in natural settings or in structured intervention programs."*

7.2. SUPPORTING EDUCATION

7.2.1. SUPPORTED EDUCATION

Early onset of severe mental health conditions can have extremely disruptive effects on young people's educational attainment, and disadvantage their later career pathways. Waghorn et al. (2004) analysed a confidentialised unit record file (CURF) from the *Survey of Disability, Ageing and Carers* Australia, 1998 (SDAC) conducted by the Australian Bureau of Statistics (ABS) and proportionally, persons with psychosis were more likely to have left school early and thus less likely to have completed secondary school than those who were recorded as 'healthy'. Whether this reflects a functional decline in the prodrome of psychotic disorders or is an epiphenomenon (e.g. a marker of other risks for psychosis such as substance abuse) is unclear. While post secondary qualification attainment was similar to the 'healthy' sample, persons with psychosis were more likely to have obtained vocational qualifications and less likely to obtain higher education qualifications in comparison. While none of the persons with psychosis aged 15-64 who had left school at age 14 or before reported being engaged in employment, there appeared to be a greater employment advantage for having completed school years 10 or 11 than for completing year 12. Additionally, vocational training appeared to facilitate employment more than higher education qualifications for people with psychosis (Waghorn et al., 2004).

This would suggest that attempts to keep people with, or at risk of psychotic disorders in certain types and duration of education may be beneficial. For instance in the latest systematic review in the area, "Supported education" is defined as being the provision of the services necessary to place and keep individuals (with severe mental illness) in integrated post secondary educational settings so that consumers can achieve their educational goals. There are different levels of

supported education, which are often combined in the literature – that for school age children and that for post secondary school with differing focus on types of mental ill health.

Waghorn et al. (2004) note that there is evidence that Supported Education programs are effective at:

> *"… increasing College enrollments and vocational outcomes (Cook & Rosenberg 1993; Mowbray et al. 1999; Unger et al. 1991); improving school retention rates (Unger et al. 2000); and improving course completion rates (Unger et al.). At an individual level, multiple benefits appear associated with the provision of Supported Education programs. Benefits may accrue through addressing education disruption and the loss of higher educational potential, and by countering secondary impacts of mental illness. Supported Education programs have been associated with decreased episodes of inpatient care (Unger et al. 1991), and increased career maturity which is so often disrupted by psychosis (Ciardiello & Bingham, 1982)."*

There is also evidence that Supported Education programs may provide benefits that reach beyond educational and employment goals: to improving overall quality of life (Collins et al. 1998; Mowbray et al. 1999 in Waghorn, 2004) self esteem (Cook & Rosenberg 1993; Collins et al.; Mowbray et al.; Unger et al.); social adjustment (Collins et al.; Mowbray et al.); and increased personal empowerment (Bellamy & Mowbray 1998; see also Rinaudo & Ennals, 2012)**.**

The literature also suggests that an important benefit of Supported Education programs is that they provide an opportunity for people to establish "*an alternative and stigma-free social identity, as students rather than psychiatric patients (Unger 1991), and when successful can address the negative impacts of self-fulfilling low expectations of clinicians, family and carers (Navin et al. 1989: 132), or counter stigma emanating from educational institution staff (Parten 1993)*" (Waghorn et al., 2004).

In research that captured the lived experience of a person living with mental illness who participated in Supported Education, studying provided a framework for socialisation and the student role was found to be empowering and positive (Rinaudo & Ennals, 2012). The student describes his experience as follows:

> *"Beginning the course, I still lacked social confidence but I was conscious of the need to reengage with people. I made a big effort to socialise at the course, and felt safe enough there to go beyond my comfort zone. I made a similar disciplined effort to improve my concentration; forcing myself to read more even though it was hard. Gradually both my confidence and concentration improved….*
>
> *…I was asked to take on the role as student representative, communicating student issues to the service management. Initially I refused, feeling overwhelmed by the demands of the role, but they reassured me that I could manage. This role made me feel like I was doing something important; like I had reengaged with an advocacy role. Doing the course boosted my confidence and self esteem. It gave me a routine; I had to be somewhere, couldn't just be late for class. I felt like this was a step to making it to a job on time.*" (Rinaudo & Ennals, 2012)

The Supported Education program also helped improve mental and physical health literacy, other skills and very importantly, appears instrumental in creating hope:

> *"In the course I had two important learning streams. I was learning more about mental illness and how to manage it from others in the class and from the teacher. She emphasised the importance of exercise and encouraged us to have healthy lifestyles so I started walking my dog, swimming and bike riding. I was also relearning skills in literacy, goal setting and regaining hope for my future.*" (Rinaudo & Ennals, 2012)

7.2.1.1. Approaches to Supported Education

Waghorn et al. (2004) note that there are a number of approaches to Supported Education, with variations on level of community integration, location of support, mix of supporting activities and the sponsoring program, however all are designed to facilitate access to post secondary education.

Unger (1990) outlines three main models of Supported Education programs:

- *"Self-contained classrooms at a post secondary facility, where students are separated from mainstream classes. Support is provided by either educational facility staff or mental health service staff.*

- *Onsite support model where students attend mainstream classes with support provided by educational facility staff.*

- *Mobile support model where students attend mainstream classes with support provided by an external agency, usually a community mental health service."*

Waghorn et al. (2004) note that there is currently insufficient evidence on what might be the most effective approach to Supported Education, thus "the choice of model usually depends on available resources and opportunities in the local environment." While yet the research does not indicate what elements are more or less required for a Supported Education program to be effective, Waghorn et al. summarise the following ten features as common and contributing to a program's effectiveness:

1. *"Coordination across other services involving a person with a severe mental illness, to prevent other services providers (e.g. mental health, income support, housing, disability support, employment) disrupting the Supported Education program (Dougherty et al. 1992; Mowbray 2000).*

2. *Specialized staff are allocated to Supported Education programs, and trained to specifically support educational objectives. This responsibility should not simply extend the case management duties of existing community mental health staff, because the role requires a high level of staff commitment (Unger et al. 1987; Walsh et al. 1991; Wolf & DiPietro 1992).*

3. *Providing specialised career counselling, including vocational planning and exploration. This element helps people identify longer-term career plans, and helps prevent people embarking on expensive study or training towards unrealistic employment goals. (Bellamy & Mowbray 1998; Bybee et al. 2000; Collins et al. 2000b; Dougherty et al. 1992; Lieberman et al. 1993; Mowbray 2000; Mowbray et al. 1999; Mowbray et al. 1993; Pettella et al. 1996).*

4. *Assistance to access financial aid or contingency funds (Bellamy & Mowbray 1998; Bybee et al. 2000; Moxley et al. 1993; Mowbray et al. 1999; Mowbray et al. 1993; Pettella et al. 1996). An Australian example is the Federal Government's Education Supplement, an additional allowance payable to persons receiving Disability Support Pension and undertaking further education.*

5. *Skill building to cope with the academic environment. Examples include: self-awareness, stress and time management (Bellamy & Mowbray 1998; Bybee et al. 2000; Collins et al. 2000b; Cooper 1993; Mowbray 2000); and academic or study skills (Bellamy & Mowbray 1998; Collins et al. 2000a; Mowbray et al. 2001).*

6. *On-campus information about student rights and resources (Bellamy & Mowbray 1998; Bybee et al. 2000; Cooper 1993; Lieberman et al. 1993; Mowbray 2000; Mowbray et al. 1993; Moxley et al. 1993; Mowbray et al. 1999).*

7. *On or off-campus mentorship and support throughout the duration of the course (Cooper 1993; Mowbray et al. 1993; Moxley et al. 1993), individual or group support (Mowbray et al. 2001), or peer support (Collins et al. 2000a; Cooper 1993).*

8. *Establish contacts within the educational institution to facilitate access to particular courses and persons able to provide within-course assistance (Bybee et al. 2000;*

Dougherty et al. 1992; Lieberman et al. 1993; Mowbray et al. 1999; Mowbray et al. 1993; Moxley et al. 1993; Pettella et al. 1996).

9. *Access to tutoring, library assistance, and other forms of supplemental educational support. (Mowbray et al. 2001; Pettella et al. 1996).*

10. *General support (off campus preferred) for the multiple individual barriers and life stressors which can lead to educational attrition (Megivern et al. 2003)."*

This is an area of service provision where much of our knowledge arises from lower quality research or process and implementation evaluation. When a more rigorous systematic review approach (contributed to by all the leading authors in the area e.g. Corrigan, Unger) was undertaken by Rogers et al. (2010), the results are less impressive. Of the 21 articles reviewed there were 4 pre-post, 3 experimental, 1 quasi-experimental, 9 cross sectional and 4 post only designs. The 4 post only design studies were excluded and methodology scores were so low that conclusions from these studies could not be considered robust or valid. Quality was not high overall and there were was *"a lack of clarity about process versus outcomes measures in supported education. One example of this lack of clarity is whether enrolment itself in an educational program constitutes a process or an outcome measure".*

The authors of the review summarise their findings bluntly and succinctly: *"Results of this systematic review of supported education suggest that there are a very few well-controlled studies of supported education and numerous studies with minimal evaluation data and less rigorous designs."*

The review concluded that:

- There are limited effectiveness data for supported education programs. In fact there is no evidence from a randomised trial or well controlled quasi experimental trial that participation in a supported education intervention results in significantly greater educational engagement or enrolment (Mowbray et al., 1999)

- There is also information to suggest that individuals with psychiatric disabilities who are enrolled in supported education programs are younger, more highly educated and less functionally impaired when compared to individuals with psychiatric disabilities in general.

- Evidence from existing studies suggests that individuals with significant psychiatric disabilities can enrol in and pursue educational opportunities in integrated settings in the community.

- There is preliminary evidence that supported education can assist individuals to identify educational goals, find and link to resources needed to complete their education and assist them in coping with barriers to completing their education.

- There is very preliminary but insufficient information that supported education can increase the educational attainment of individuals with psychiatric disabilities.

- Because many studies are short term and focus on course completion, there is no rigorous evidence to suggest that supported education will lead to a greater number of individuals with psychiatric disabilities possessing advanced degrees or certificates.

Importantly, there was *"no rigorous evidence to assert that supported education leads to higher employment rates among participants."* (Rogers et al., 2010)

7.2.2. ALTERNATIVE EDUCATION/REMEDIAL EDUCATION

Alternative education is a term used broadly to describe educational services that are delivered outside of the convention school system. These programs are designed as alternatives to mainstream schooling that are flexible and socially inclusive. In Australia, alternative education programs typically support vulnerable youth who have already dropped out of school (Wilson et al., 2011).

> *"Alternative options to the basic academic route are fundamental in terms of giving those most at risk a clear pathway with achievable goals. Programs that force individuals to*

stay in formal academic education may lead to more harm than good as lower-grade academic qualifications … are not highly regarded by potential future employers." (Britton et al., 2011)

A review of 400 alternative education programs in Australia found that such programs are promising, yet lack an evidence base (Britton et al., 2011; Te Riele et al., 2012). This is primarily due to a substantial diversity in program practices, lack of funding and difficulty sustaining programs, and the dearth of adequate impact measurement and program evaluations.

Despite the noted fragmentation of research and practice in alternative education programs, there is some uniformity in the literature regarding best practice principles:

- *"offering activities that are meaningful and relevant that they can participate in voluntarily;*

- *delivering learning in an environment that is not like a school;*

- *providing one-on-one support for young people, tailored to individual needs and circumstances;*

- *employing staff with the skills and qualities necessary to develop meaningful and supportive relationships with young people; and*

- *establishing strong links with schools and other agencies to support the transition of young people into further education or training."* (Spielhofer et al., 2009)

In addition, Mills and McGregor (2010) examined best practice from the perspective of young people attending alternative education programs in Queensland. Students highlighted the following as being important:

- *"learning programs – opportunities to undertake traditional subjects and curricula as well as workplace training and access to vocational qualifications;*

- *learning environment – relaxed school climate, flexibility, staff–student dialogue and negotiation, voluntary attendance, sense of community;*

- *teaching relationships – accepting students for who they are, respect between staff and students, young people feeling "celebrated", receiving sufficient time and assistance to complete work, "connected" and "conversational" teaching strategies." (*Mills & McGregor, 2010)

Based on these student reports, Mills & McGregor recommended the following elements of good practice:

- *"Provision of appropriate curricula that suit the needs of students and provide them with pathways towards work and further education;*

- *Flexibility to develop diverse curricula responsive to the needs and aspirations of young people who choose to attend alternative settings; and*

- *Curricula connected to young people's worlds that value the diversity of the student population while maintaining concern with learning that is intellectually challenging."*

7.2.2.1. Alternative education versus supported education

There is a small amount of overlap between alternative education and supported education. Much like alternative education programs, the self-contained model of supported education separates students from mainstream classes and provides extra support via educational staff or mental health staff. There are three key differences between alternative education and supported education:

1. Supported education has an emerging (albeit limited) evidence base. While alternative education programs are viewed as promising, as yet there is no evidence of impact, primarily due to a lack of rigorous program evaluations.

2. Supported education is based on the principles of the IPS model of supported employment. Fidelity to these principles is considered to be an important success factor. Meanwhile, there is considerable fragmentation in alternative education programs.

3. While supported education is targeted specifically towards people with mental illness, alternative education caters for young people with a range of barriers to mainstream education.

Alternative education programs have been defined as programs designed to support students who are unlikely or unable to access mainstream education for one or more of the following factors:

- *"alienation from the mainstream school environment due to long-term nonattendance and truancy*

- *social and family issues such as parenting style, poor connections to parents/ caregivers, a history of residing in alternative care, homelessness, family dysfunction and violence, poor personal social skills, personal behavioural difficulties, substance misuse*

- *environmental issues such as poverty, child neglect and maltreatment, and poor access to community and support resources*

- *engagement in criminal activity, justice involvement or periods of detention*

- *mental health issues, particularly when combined with aggressive behavior*

- *unwillingness to attend mainstream school due to past experiences such as peer relation issues*

- *inability to access the curriculum due to extremely poor literacy and numeracy."* (de Jong & Griffiths, 2006)

Many young students are reluctant to seek help for mental illness, or may simply not view themselves as having a serious mental health concern. Such students are thus unlikely to access supported education programs that specifically target those with mental illness. Despite the current lack of evidence, alternative education programs appear to be a critical support structure due to their ability to cater for students with a broad range of barriers to education, and hence capture disengaged young people who may otherwise not seek mental health care or specialised services.

7.2.2.2. Advantages and disadvantages of alternative education programs

The following strengths of alternative education programs have been highlighted:

- Aiding transitions for young people with high support needs

- Provision for cultural diversity

- Flexibility and choice

The flexibility of alternative education programs is key. Adult learning principles were highly valued by students participating in the Brotherhood of St Laurence Community VCAL program in Victoria. These disengaged young people reported that they disliked the rules and inflexibility associated with mainstream schooling. These are young adults who have in some cases endured significant trauma and struggles at an early age. Students reported that they resented being treated like children. Students in this program valued adult learning principles which allowed them to make decisions about their own learning, to leave the classroom as they pleased (much like a university environment), and to dress however they liked (Myconos, 2011).

Similarly, the SCISCO Career Pathways program in Queensland provided a flexible curriculum which was adjusted daily to accommodate for students' wellbeing needs. For instance, students were encouraged to take on a lighter workload on 'mental health days' (Knight, 2012).

Nonetheless, alternative education programs have been criticised for the following (de Jong & Griffiths, 2006):

- Some alternative education programs may take a deficit approach in which the focus is on 'fixing' the student.

- Students may be 'contaminated' by the anti-social behavior of other students.

- There is some stigma attached to alternative education, which may encourage students to believe that they are incapable.

- Lack of funding and resources makes program sustainability challenging.

Importantly, there are concerns that the availability of alternative education programs encourages an 'intolerance to difference' within mainstream schools. That is, rather than make the necessary adjustments, mainstream schools may view alternative education programs as a 'dumping ground' for struggling students (de Jong & Griffiths, 2006).

The Peninsula Youth Connection program evaluation reported a high proportion of young people for whom mental illness, family, accommodation and financial issues were primary barriers to engagement.

> "Whilst these are barriers to engagement at school, they do not reflect the individual young person's interests, capabilities and aspirations. Alternative education and training settings are one important strategy, however care needs to be taken in shaping policy to ensure that students are not indiscriminately funnelled into alternative settings by consequence of their backgrounds or the challenges they face, as opposed to their aptitudes and preferences." (Barrett, 2012b, p. 15)

Thus, while alternative education programs may provide crucial support for many disengaged young people struggling with mental health, it is important that support is enhanced within mainstream schools. Many young people may be academically inclined and disengaged primarily because of mental health concerns. In such cases, increased mental health support within the school may be more appropriate.

On a related note, the Peninsula Youth Connections evaluation found that the program was most effective for young people with mental illness. Additionally, young people with mental health concerns required shorter program durations to achieve positive outcomes. The Peninsula Youth Connections program was one that adequately addressed mental health concerns. Such a finding suggests that addressing mental health concerns may go a long way towards increasing engagement, perhaps even within mainstream schools.

7.2.3. POST-SECONDARY EDUCATION

7.2.3.1. Students' mental health

Stallman (2009), in a study of nearly 6,500 students (mostly aged 18-24) from two large Australian universities, found preliminary evidence of very high levels of psychological distress (83.9% of students surveyed reporting elevated distress levels compared with 29% in the general population). The students experiencing the highest levels of psychological distress were those in their second and subsequent years of undergraduate study, followed by first year students. The research indicated that "Protective factors may include students living with family or in university housing, as those in flat-sharing accommodation fared worse."

Certain groups of students may be more at risk of psychological distress. For example, an Australian study found that law students had significantly higher distress levels compared to students in other disciplines, including Medicine (Kelk et al., 2009).

7.2.3.2. Increasing prevalence and complexity of mental health conditions

A number of researchers have identified an increasing trend in the prevalence of clinically diagnosed mental health conditions (Cook, 2007; Osberg, 2004; Simpson & Ferguson, 2012). Benton et al. (2003) found an increase not only in the numbers of students presenting with

diagnosed mental health conditions, but also the complexity of the issues. Guthman et al. (2010) noted increases over a decade in the numbers of students presenting with depression. Suggested explanations for these increases include greater numbers of students enrolling in further study with pre-existing conditions (Guthman et al., (2010)); and increases in student diversity leading to more students from at risk population groups (Simpson & Ferguson, 2012).

In addition to the increases in prevalence, student numbers generally have also increased, so there are now greater demands placed on educational institutions' counselling services. Simpson and Ferguson (2012) note that at the authors' own university, client numbers had doubled over 2004-2010, with a 15% increase in urgent cases over 2005-2010.

According to the University of Sydney's Counselling and Psychological Services (CAPS), just under 5% of the total student body presented for assistance during a ten month period from January 2011, while the numbers of those at the "acute end of the mental health spectrum are increasing both in frequency and severity, and require an immediate deployment of already committed resources." (University of Sydney Counselling and Psychological Services, 2011)

7.2.3.3. Mental health and academic performance

Simpson and Ferguson (2012) highlight research undertaken by La Trobe University's Counselling Service that found that "students with diagnosed mental health conditions reported difficulties with motivation, concentration, and confidence, all of which impact negatively on the ability to persist and succeed in a tertiary environment" and that "… a number of authors have found that psychological symptoms are a significant predictive factor of student retention (Fisher & Hood, 1987; Osberg, 2004). "Emotional health" was the highest rated reason contributing to student attrition in the Centre of the Study of Higher Education (CSHE) student experience survey in 1999, 2004, and 2009 (James, Krause, & Jennings, 2010). Students experiencing mental health symptoms, and who remain untreated, are thus far more likely to leave university before completing their studies."

7.2.3.4. Literature available on how to better support students

The literature available on supporting students with mental health conditions in higher education is sparse (Reavely, 2013) and much of it emanates from the US, which has very different educational systems. Given the reported high levels of student distress, there is an urgent need for more Australian research to inform better student care.

7.2.3.5. Clinical Services and Counselling Support

To date, there are few published evaluations of the effectiveness of counseling in the university context (Minami et al., 2009, p. 310), however, there is a general belief that student counselling services can provide meaningful support for students in need. Wilson et al. (1997), in a study that analysed the records of 562 students, found that student retention was positively correlated with the number of counselling sessions up to a maximum of 6 sessions.

Despite the perceived benefits of seeking counselling, there are low rates of disclosure and help seeking amongst students. Storrie et al. (2010, p. 4) report that most students not getting the help they need, noting US research that indicates that "90% of students with emotional problems never used counselling during the previous 6 months. More than three-quarters of students with significant distress—that is, requiring mental health services, did not receive counselling" (Collins & Mobray, 2005; Rosenthal & Wilson, 2008).

7.2.3.6. Pastoral care and whole of university support

Simpson and Ferguson (2012) note that there is growing recognition in the literature of the need to take an integrated and whole of university approach to supporting the mental health of students:

> *"Historically, student support services have been the primary means of dealing with students with mental health concerns. The result is that services are seen as the only*

solution to the problem. This has segregated services from the rest of the institution and placed the bulk of the responsibility for mental health onto counselling staff members. However, this model is no longer sufficient to meet student demand and universities will need to develop ways of incorporating mental health awareness throughout the institution." (p. 6)

Laws and Fiedler (2012) notes research that shows that academic staff are taking on a greater role in providing pastoral care and other student support, for example a survey of higher education lecturers and tutors in the UK found that:

- 77% had a student support role for 5 years or more.

- 80% described their role as a combination of pastoral and study support.

- 69% (approx.) were able to recall particularly challenging student support encounters.

- 70% had occasions when they needed more support such as debriefing or offloading after a difficult session with a student. (Laws & Fiedler, 2012)

Hyun et al. (2006) found that *"...for students in distress, contact with sympathetic administrative staff and faculty advisors who are willing to direct them to appropriate services is critical"*. Aschenbrand et al. (2005) found that performance was better in students who felt emotionally supported than in students who did not. Simpson and Ferguson (2012, p. 6) posit that *"Ideally, all staff should be equipped in recognizing the mental health needs of students, comfortable being proactive in asking students if they require support, and knowledgeable about what follow-up action to take on behalf of an individual they are concerned about."*

However, researchers have raised concerns about the attitudes of academic staff towards students with mental health conditions expressing that they are not always helpful, and often view emotional difficulties as 'behavioural problems', with such misconceptions compounded by a lack of training (Warrick et al., 2008; Storrie et al., 2010; Collins & Mowbray, 2005)

Laws and Fiedler (2012) raises the difficulties that academic staff face in modern tertiary institutions where they are expected to provide pastoral care and support for students, yet are themselves subject to high levels of psychological distress and competing demands. Huytun (2009) uses the term 'emotion work' to describe the pastoral care that academics are often expected to provide students, despite it often not being recognised in their workloads. Huytun, and Laws and Fiedler (2012) suggest that this work should be better recognised and valued.

7.2.3.7. Stress Management

A systematic review of the literature and meta-analysis into the effectiveness of interventions aimed at reducing stress in university students found that there was *"strong support that cognitive, behavioral, and mindfulness-based approaches are effective in reducing the effects of stress on university students, including reducing levels of anxiety, depression, and cortisol response"* (Regehr et al., 2013, p. 10). However, a limitation in existing studies is the over-representation of interventions conducted among female participants in Western countries (this could be due to females having higher rates of anxiety and depression, as well as being more likely to seek help than males), hence further work needs to be done on how to attract male students to such programs.

7.2.3.8. Mental Health Awareness

In reviewing the literature, Simpson and Ferguson (2012) found evidence to suggest that only 20 per cent of students who need help actually seek it (Furr, et al., 2001 in Simpson & Ferguson, 2012) and suggests that universities will need to develop more innovative and efficient ways of reaching larger numbers of students. Simpson notes one innovative example where the University of Hong Kong offered:

"…a semester long assessed course in mental health literacy which introduced the concepts of stress, depression, and suicide. The course was open to all undergraduate students, regardless of the student's background or chosen course. Utilizing a cognitive-behavioral approach, students were given techniques for reflecting on their mental state

and strategies for dealing with stress, low mood, anger, and conflict. In 2007-08, approximately 220 students from a range of backgrounds enrolled in the course. The university's rationale for introducing the course was that university students require "both intellectual and psychological competences to meet future challenges." (Wong, 2009 in Simpson & Ferguson, 2012)

7.2.3.9. What could help retain students with mental health conditions?

The US based National Alliance on Mental Illness (NAMI, 2012) conducted a national survey of college students living with mental health conditions and asked them to identify enabling factors and barriers to academic success and engagement. There appears to be no Australian equivalent.

The survey also included students who had dropped out and provided the following responses when asked what might have helped them stay in school:

- Receiving accommodations (e.g., tutoring, books on tape, lower course loads, help with communicating their needs to professors or online classes).

- Accessing mental health services and supports on campus to help them address mental health issues impacting their academic performance.

- Connecting with mental health providers earlier.

- Having peer-run support groups available.

- Getting assistance with medical bills and transportation.

- Managing side effects of medications.

- Getting support from family and friends.

The NAMI survey found that stigma (and associated fear of disclosure) remains the biggest barrier to students seeking help, with one survey respondent stating:

"It is extremely difficult for students to come out and talk about mental health problems and they may not want to tell you this is why they are falling behind, missing class, seeming disengaged, etc. Please be sensitive and understand mental health problems are 'real' problems. Encourage them to find help through the health center and academic advising." (NAMI, 2012, p. 22)

7.2.3.10. Supporting students with mental illness in tertiary institutions - results from a Delphi consensus study

Noting the paucity of evidence on how to provide support to students with mental illness in tertiary education, Reavely (2013) conducted a Delphi consensus study with two panels consisting of professionals and consumers. The construction of the 72 item survey instrument was informed by a systematic review of grey and academic literature.

The Delphi consensus study produced the following key points for tertiary education institutions to facilitate improved educational outcomes for students with a mental health problem (Reavely, 2013, p. 43):

Have a policy around supporting students with a mental health problem:

- *The institution should have a mental health policy covering mental health promotion, mental illness prevention and services for students with a mental illness.*

- *The mental health policy and its implementation should be driven by senior management in partnership with students with mental illnesses, staff from different areas of the institution, student associations and representatives of outside services.*

- *The institution should have a strategy for communicating its mental health policy to staff and students.*

- *Provide support to students with a mental health problem*

- *The disability office should make all staff aware of the range of services they provide to assist and educate staff supporting students with a mental illness.*

- *Support services should develop a mental health promotion strategy which covers prevention, early identification, stigma reduction, availability and access to services.*

- *Support services should provide all staff and students with education on mental illness.*

- *The institution's support services should adopt an easy access and "no wrong door" policy to entry for assessment and treatment of mental health problems.*

Provide reasonable adjustment for students with a mental illness:

- *Staff should be provided with information about making reasonable adjustments for assessments.*

- *The process for getting reasonable adjustments should be as simple as possible and advice should be available to students if needed.*

- *Have procedures for making staff and students aware of issues around mental illness*

- *These should include signs and symptoms, causes and treatments, the importance of prevention and early intervention and how to support students with a mental illness in ways that promote recovery.*

- *Support services staff should receive appropriate and ongoing professional development and training in relation to mental illnesses.*

- *The institution should provide staff with training and information about the following:*
    - *The use of non-judgemental listening skills when talking with students about their personal problems.*
    - *How to respond when a student discloses a mental illness to them, including which things are supportive and which are unhelpful.*
    - *Techniques for promoting motivation and self-esteem in students with mental illnesses.*
    - *Curriculum design, development and delivery strategies that facilitate inclusive and effective learning for students with mental illnesses.*

Classroom, examination and assignment adjustments that can be made for a student with a mental illness:

- *Make students aware of their rights and responsibilities*

- *Staff should be informed about how to handle mental health crisis situations.*

Interact with students with a mental illness in a manner that maintains respect, dignity, confidentiality and equity:

- *When a student discloses that they have personal issues such as a mental illness, confidentiality should be respected unless there is an immediate danger to the person or to others in withholding that information.*

- *If the student has a mental illness, staff should not make assumptions, but rather ask the student what support, if any, they might need.*

- *Staff should explore any challenges or barriers to successful learning with students with a mental illness.*

Allocate resources to funding and evaluation:

- *Adequate funds should be allocated to provide support services to students with a mental illness.*

- *Institutions should seek funding opportunities that can be used to help develop and enhance support services for students with a mental illness.*

- *The institution's mental health services should be subject to ongoing research and evaluation of their service provision.*

7.3. SUPPORTING WORK

7.3.1. BARRIERS TO EMPLOYMENT

Waghorn and Lloyd (2005, p. 20-26) identified the large number of direct and indirect barriers for people, not just youth, with mental illness:

- **Cognitive impairments as barriers to employment:** it has only been in recent years that the investigation of cognitive deficits and their effects on employment have received attention, possibly due to the inability of previous research to make a clear link between cognitive functioning and employment outcomes. Waghorn and Lloyd state that cognitive deficits consistently found in schizophrenia or schizoaffective disorder include *"generalised deficits such as lowered full-scale IQ and a reduced capacity for information processing"*, while more specific deficits can include *"problems with attention, sustained attention, memory and executive functioning"*. More recent studies suggest that *"cognitive symptoms are likely to cause employment restrictions, which limit occupational choice through restricting the type of work activities which can be successfully performed. Industry and job choices can be restricted, work hours and work performance may be limited, and the need for on-going assistance to retain employment may be increased. In addition, general cognitive deficits as well as deficits in social cognition are associated with impaired work-related social skills, and may underlie the impaired social competence which can influence vocational outcomes."* Waghorn and Lloyd do not comment on whether exclusion from education and failure to obtain early intervention have contributed to impaired cognitive functioning.

- **Other clinical symptoms as barriers to employment:** many of the clinical symptoms associated with mental illness can directly contribute to employment barriers and may also impair social skills development. Yet as potentially disabling as psychiatric symptoms can be, a number of studies have found that they are not reliable predictors of vocational outcomes and instead, a review by Tsang et al. found that the *"most consistent predictors of employment outcomes were found to be work history, premorbid functioning and current social skills."*

- **The episodic nature of the disorders as a barrier to employment:** the episodic and fluctuating nature of many people's experience of mental illness can be problematic in two ways. Firstly, there is the distress and disruption during episodes and secondly, in periods of relative stability, people can have their needs underestimated and thus not have access to adequate protective support. Indeed, the authors found that *"reliance on clinical symptom measures can lead to the flawed conclusion that reduced symptoms indicate reduced employment or education assistance needs. A better way to assess career related assistance needs is to take account of predictors and correlates of employment outcomes, namely level of employment restrictions, lifelong course pattern of illness, premorbid functioning, educational attainment, relevant work history, relevant vocational skills, and current social skills."*

- **Treatment interventions as indirect barriers to employment:** Barriers can arise from both pharmacological and psychological interventions through side effects of medication, the time in which it can take for treatment to manifest effects, and sub-optimal treatment that can lead to poor adherence and exacerbation of symptoms. Waghorn and Lloyd recommend that clinical treatment and vocational rehabilitation interventions *"…need to be coordinated so that changes to treatment plans (e.g. a new medication trial) do not conflict with planned vocational activities. Sometimes treatment goals need to be balanced by vocational goals. For instance, some residual positive symptoms may be preferred to a symptom free state with lowered energy levels, insufficient to sustain preferred hours of employment. Failure to actively coordinate interventions by treating and vocational professionals may create a coordination barrier*

to employment, placing the onus on the person least likely to manage this responsibility, to coordinate treatment interventions with rehabilitation activities."

- **Low vocational expectations by health professionals:** evidence of health professionals having low expectations of the ability of consumers to work and thus, not readily assisting and encouraging vocational uptake. Instead prevocational programs were more likely to be emphasised and opportunities missed to build on the consumer's motivation to work.

- **Community stigma as a barrier to employment:** Stigma and discrimination continue to create significant barriers to employment by limiting participation opportunities and full inclusion elsewhere in the community. The experience of which can lead to avoidant disclosure strategies, which can limit further workplace accommodations.

- **Stigma among helping professionals as a barrier to employment:** Stigma can manifest in low vocational expectations by health professions as noted above. Stigma can also manifest itself among vocational professionals *"…as a reluctance to assist people with psychiatric disabilities if staff lack confidence or are inadequately trained to assist this category of disability… Consequently, people with mental illness may be unfairly excluded from vocational assistance, have their support needs incorrectly estimated, or may not receive suitably intense or continuous forms of assistance."*

- **Comorbid disorders as a barrier to employment:** People with other comorbid health conditions or disability *"…may be more likely to be excluded from vocational assistance through being perceived as too difficult to assist"* despite overseas evidence that indicates that *"comorbid: substance use disorders, personality disorders, physical health conditions, intellectual disability, acquired brain injury, or mental illness associated with a forensic history, are not valid grounds on which to deny people access to vocational services."* Waghorn and Lloyd note that there is anecdotal evidence of people being excluded from services, including services specialising in psychiatric disability, on account of having comorbid disorders, and that there needs to be more research conducted into the ability for those with more severe and complicated forms of mental illness to access appropriate vocational services.

- **Workplace stigma:** Workplace stigma and discrimination can lead to barriers to the hiring, retention and promotion of people with mental health conditions. Disclosure and stigma are discussed at greater length later in this report.

- **Confusing terms, definitions and measures as barriers to employment:** Waghorn and Lloyd contend that *"Conflicting descriptions and definitions of mental illness and psychiatric disabilities and multiple overlapping mental health terms create confusion among policy makers and service providers, often preventing the different service systems from adequately responding to the needs of individuals and sometimes creating tension between different service systems."*

- **Government funding structures as barriers to employment:** The complexity of funding structures and the multiplicity of services often require far from easy navigation to gain assistance and support. The co-ordination roles that could assist people with mental health conditions with this navigation, are unfortunately lacking. Waghorn and Lloyd also suggest that case-based funding and limits on support places have, anecdotally, led to people with more severe forms of mental illness being excluded from the most suitable forms of vocational assistance.

- **Disincentives in the health and income support systems:** Waghorn and Lloyd point to work disincentives that can exist within the health, social welfare and income support systems, whereby benefits and discounts may be lost and difficult to regain if employment is obtained. The authors note that this *"… may be particularly important for people with psychiatric disabilities because of the difficulties qualifying for income support due to the episodic nature of the disorders and the greater difficulty with employment retention compared to other disability categories."*

- **Rural and remote locations as barriers to employment:** People living in rural and remote locations can face greater disadvantage due to the *"…reduced availability of: public mental health services, private psychiatrists, general medical practitioners,*

disability employment services, vocational rehabilitation and Job Network services. In addition, career opportunities can be restricted to pastoral, mining and rural service industries."

- **Career immaturity as a barrier to employment:** Prior exclusion from the workplace and opportunities to participate in the community can lead to a lack of exposure to workplace practices that could have helped *"… a person form appropriate work perceptions, work confidence, work interests, work values and work ethics. Although the precise psychological processes are unclear, it is likely that career maturity is influenced by the person's life experiences, personality, perceptions of illness experiences, family background, educational attainment, work values, and knowledge of workplaces and employer requirements."*

- **Subjective experiences and personal resources as barriers to employment:** These can include internal barriers such as *"… unpredictable sleeping patterns, fear of failure, fear of relapse, lack of confidence in vocational abilities, difficulties with concentration, and fear of resuming work after years of unemployment."* Mallick et al. (1998) found that the greatest barriers to community integration were a lack of financial resources, employment resources (that is, "employment opportunities and available resources to find a job and maintain employment"), and vocational skills.

Lloyd and Waghorn (2007), in looking at the importance of vocation in recovery for young people with psychiatric disabilities categorised these barriers into three types:

1. **the impact of mental illness on the person:** such as cognitive, positive, negative and disorganised symptoms that can be associated with severe mental illness.

2. **external barriers such as the nature of the labour market and the availability of suitable employment assistance:** such as limited flexible options for work that can accommodate the disability and lack of time-unlimited support that can leave people with inadequate support for the fluctuating nature of mental illness.

3. **other systemic barriers to employment such as stigma and discrimination.**

7.3.2. SUPPORTING WORK FOR YOUNG PEOPLE LIVING WITH SEVERE MENTAL ILLNESS

For people with severe mental illness, there are two main approaches to providing rehabilitative vocational assistance, though the terminology used varies among countries, researchers and practitioners. They differ in their initial view of the person's readiness for competitive employment, that is a job in open employment market that is paid at the market rate.

The first is the ***train and place*** approach. This is also known as the traditional model where the assumption is that before a person can enter sustained competitive employment, they first need extensive preparation (usually termed 'prevocational training') for and gradual introduction to the workplace (Urbis, 2008). This approach can include job skills and job clubs, volunteering, sheltered workshops or work crews, and transitional employment (short term placements in open employment)[1]. The main goal here is to acquire work experience and skills (Rose & Harris, 2005) and in fact, the person may never be placed into competitive employment.

The second is the ***place and train*** approach where the goal is to get the person into competitive employment quickly and provide ongoing support and assessment once the person is in the workplace, avoiding lengthy prevocational training. This is commonly referred to internationally as 'supported employment' (in comparison to the Australian usage) with provision of intensive long-term on- and off-the-job support provided by job coaches or employment specialists (Rose & Harris, 2005). There is general consensus amongst the more recent literature that place and train (supported employment) models generally provide better outcomes for people with mental illness than *train and place* (sheltered, traditional and

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[1] Although in an Australian context this is sometimes referred to as "supported employment" in Australia in this report that term is used in its more commonly accepted international definition, as described in the next paragraph.

transitional) models, where there is more of an emphasis on preparation first. According to Evans and Repper (2000, p. 17):

> *"Much of the American research is unanimous on one point: supported employment services offer greater promise than do sheltered or transitional employment approaches (Lehman 1995). Support needs to be provided in real workplaces with skilled support 'titrated' to meet the individual's fluctuating needs. Initiatives based on this model have demonstrated superior outcomes even with some of the most vulnerable of users (Stein & Santos 1998). What sets supported employment approaches apart is that they focus from the onset on placing people in real and permanent jobs, regardless of their perceived level of disability. For most of the other approaches, this is the exception rather than the rule."*

Further reviews (Bond, 2004; Twamley et al., 2003; Crowther et al. 2001) have also found that supported employment initiatives consistently outperform traditional initiatives. Waghorn et al. (2009) suggest that traditional approaches delay the potentially positive benefits of employment and add to the persistence of feelings of exclusion from the mainstream.

7.3.3. INDIVIDUAL PLACEMENT AND SUPPORT (IPS)

The literature identifies Individual Placement and Support (IPS) models as the most effective of evaluated supported employment initiatives (Bond et al. 2008). The underlying philosophy for these models is that "*anyone is capable of working competitively in the community if the right kind of job and work environment can be found and the right kind of support provided. Thus, the primary goal is not to change the individual, but to find a natural match between the individual's strengths and experiences and a job in the community.*" (Rinaldi et al., 2008)

Key principles that are intrinsic to the IPS model are (Becker & Drake, 2003; Bond, 2004):

- **Services Focused on Competitive Employment:** *The agency providing supported employment services is committed to competitive employment as an attainable goal for its consumers with SMI, devoting its resources for rehabilitation services to this endeavour, rather than to intermediate activities, such as day treatment or sheltered work. Supported employment programs focus on helping consumers obtain their own permanent competitive jobs.*

- **Eligibility Based on Consumer Choice:** *No one is excluded who wants to participate. The only requirement for admission to a sup- ported employment program is a desire to work in a competitive job. Consumers are not excluded on the basis of "work readiness," diagnoses, symptoms, substance use history, psychiatric hospitalisations, or level of disability.*

- **Rapid Job Search:** *Supported employment programs use a rapid job search approach to help consumers obtain jobs directly, rather than providing lengthy pre- employment assessment, training, and counselling.*

- **Integration of Rehabilitation and Mental Health:** *The supported employment program is closely integrated with the mental health treatment team. This principle means that supported employment staff participate regularly in treatment team meetings and interact with treatment team members outside of these meetings.*

- **Attention to Consumer Preferences:** *Services are based on consumers' preferences and choices, rather than providers' judgments. Staff and consumers find individualised job placements, based on con- sumer preferences, strengths, and work experiences.*

- **Time-Unlimited and Individualised Support:** *Follow-along supports are individualised and continued indefinitely. Supported employment pro- grams remain committed to the support of consumers long after they have achieved employment, avoiding artificial deadlines for pro- gram terminations that may be dictated by funding sources. (Bond, 2004).*

Waghorn and Lloyd (2005, p. 31) add five further principles of effective vocational services in use in Australia:

- *Personalised benefits counselling (this is also sometimes included as the 7th principle in the IPS model)*

- *Intensive on-site support*

- *Multidisicplinary team approach*

- *Emphasis on the rehabiliation alliance*

- *Stigma and disclosure strategies*

7.3.4. MODEL FIDELITY AND TRANSLATION TO AUSTRALIAN CONTEXTS

Harvey et al. (2013, p. 422) note that while *"the setting does not appear to be important in predicting the success of IPS, unlike non-IPS employment models (Marwaha et al., 2007), model fidelity is vital. A number of studies and a recent systematic review have shown that IPS services that are able to meet the key requirements [competitive employment as the goal, zero-exclusion policy, rapid job search, integrated vocational and clinical services are integrated, individual preferences guide job search, time-unlimited support, personalise benefits counselling], are more successful at obtaining employment for people with severe mental illness (Bond et al., 2012)."*

Waghorn et al. 2007 identified specific challenges to implementing evidence-based supported employment, such as IPS, in Australian contexts. Major challenges included:

> *"integrating federally funded disability employment services with community mental health services, and the need for zero exclusion criteria… …The sites reporting early success implementing IPS evidence-based practices and overcoming barriers to employment-health service integration seemed to adopt a strategy committed to the goals of high fidelity approaches from the outset, by only using a full-time employment specialist with a new case-load capacity, and by co-locating one employment specialist in the most relevant treatment team. Sites reporting the most initial difficulty, had either attempted non-orthodox co- location (e.g. co-location with a separate rehabilitation team), or attempted to provide an integrated service with a part-time employment specialist.* (Waghorn et al. 2007, p. 34)

7.3.5. APPROPRIATENESS FOR YOUNG PEOPLE AND IMPORTANT OF EDUCATIONAL PATHWAYS

Further research has been conducted on whether the IPS model is suitable for young people, with qualified support being found for its use. Porteous & Waghorn, (2007) identify two reports (Killackey, Jackson, & McGorry, 2008; Porteous & Waghorn, 2007) that show *"vocational outcomes of 60-80% can be expected in New Zealand or Australia, when the service users are young people with early psychosis, and formal study options are added to competitive employment as the primary vocational goals"* (Porteous & Waghorn, 2009, p. 34).

While supported employment models preference rapid job entry over training outcomes, these models were developed for adults, many of whom had experienced repeated exclusion from the workforce, and as such these models do not recognise the different experiences and career aspirations of young people. Waghorn et al. (2007) in a study of early implementations of Australian supported employment sites, found two sites with a focus on youth had added a supported education program. The authors noted that "*This type of program can help young people with psychosis restore illness-disrupted secondary and vocational education where this is congruent with a viable career plan. Not addressing education disruption can flatten potential career trajectories, constraining people to entry level employment or to lower paid, less skilled, less satisfying, and more labor intensive jobs (Baron & Salzer, 2002)"* (p. 33).

7.4. SUPPORTING WORK FOR YOUNG PEOPLE LIVING WITH MILD-MODERATE MENTAL ILLNESS

In contrast to the literature examining interventions focused on people with severe mental conditions, there is a notable lack of evidence-based models which aim to improve the employment outcomes of people with mild to moderate mental health conditions (e.g. depression and anxiety).

Underwood et al. (2007) conducted a systematic rapid evidence assessment of the effectiveness of interventions for people with common mental health problems on employment outcomes. Despite the greater prevalence of common mental health conditions, there was vastly more research conducted on interventions with severe mental health conditions (135 out of 155 studies). The researchers noted that studies with a focus on common mental health conditions could be classified as 'mental health interventions' where the focus was on improving mental health treatment, or 'employment interventions' which instead aimed to assist people in gaining or retaining work. While the researchers had concern for the variability of research quality and relevance, they found that *" … the evidence suggests that 'mental health' interventions can improve the employment status of people with common mental health problems, especially for those already employed. The evaluations of 'employment' interventions tended to be less robust and could not provide conclusive evidence that these programmes are effective"* (Underwood et al., 2007, p. 2). There was a prominent gap in evidence-based interventions for people who were unemployed. The researchers also reported that while the employment interventions were poorly evaluated and thus couldn't be found to have created positive outcomes for employment, there was evidence that these initiatives were well accepted by stakeholders and may have had other benefits.

The researchers made the following assertions (qualified by the paucity of available research):

- *"Improvements in mental health are associated with better employment outcomes. (It should be noted that this is an association, and not necessarily causal.)"*

- *"Receiving recommended primary care improves employment outcomes."*

- *"Interventions to improve mental health guideline implementation and adherence can improve employment outcomes"* (Underwood, 2007)

A Cochrane review of interventions to improve occupations health in depressed people (Nieuwenhuijsen et al., 2008) found little evidence of what works. Where there was limited evidence of a positive effect of a clinical intervention, it was not recommended in treatment guidelines. The researchers did not identify any work-directed studies, though this was partially explained by the research's focus on treatment studies of workers with depressive disorders:

> *"Once a worker has developed a disorder, interventions to prevent consequences, such as sickness absence and work disability, are needed such as individual work accommodation. In contrast, preventive studies involving organisational changes to eliminate risk factors such as lack of social support at work or work overload are directed at healthy workers.*
>
> *Nevertheless, the lack of work focus in interventions for workers with depressive disorders is more difficult to explain. Recent findings from an observational study (Adler 2006) show that symptom remission is associated with improved work functioning, but deficits remain in the work- place performance of recovered workers. This suggests that in addition to receiving clinical treatment, depressed workers need work support and accommodation in order to work effectively. Among the interventions suggested in the literature are CBT or problem- solving approaches towards workplace issues, and the adaptation of supported employment strategies, which are now being used for individuals with severe psychiatric disabilities, and employee assistance programs (Adler 2006; Bilsker 2006). The efficacy of these interventions needs to be tested in future randomised controlled trials."* (Nieuwenhuijsen et al., 2008, p. 11-12)

The researchers recommended that future research into clinical interventions include occupational outcomes such as sickness absence and work function.

Likewise, Henderson et al. (2011) found that *"… the relatively sparse evidence available reveals a complex field with significant interplay between medical, psychological social and cultural factors. Sick leave can be a 'process' as well as an 'event'."* The researchers note that there was some support for a large trial of depression screening in the workplace which was *"… followed by a systematic programme of telephone outreach and care management (encouraging employees to enter appropriate treatment and monitoring treatment quality)"* and which *"… resulted in decreased symptoms, higher job retention and more hours worked.*" Though the researchers caution against this finding with other research, which indicates *"screening for depression is not associated with improved outcomes."*

None of these studies appear to have looked specifically at interventions or outcomes for young people. There is clearly an urgent need for more research in this area.

7.5. INTEGRATION OF EMPLOYMENT AND MENTAL HEALTH SERVICES: CO-LOCATION AND IMPROVING INTERSECTORAL LINKS

A key principle of the IPS model for improving vocational outcomes for people with severe mental health conditions is the integration of rehabilitation and mental health support. The supported employment program should be an integral part of the mental health treatment plan, with specialists from employment and mental health in regular communication with each other (Bond, 2004).

Integration does not necessarily mean co-location, and co-location does not necessarily result in integration, however, co-location can reduce the costs and barriers to integration (King et al., 2006). Co-location of services is the preferred model for enhancing vocational opportunities for people with severe mental illness as it can facilitate better co-ordination of vocational and health treatment plans (King et al., 2006). Co-location may also have other benefits for consumers: it can be more convenient to have services located in one place. Another possible benefit was raised in a study of barriers to mental health service access for youth in rural Australia. In this context, it was suggested that co-location of services could help to protect people's privacy and improve access because if the consumer was seen to be visiting the service, it would not be clear that it was for mental health treatment (Aisbett et al., 2007). This is particularly an issue where a community is small and there is high level of stigma against those with mental illness. One young participant stated:

> *It was better when it was up at the hospital, yeah because you could just be going into the hospital to see someone, like yeah, because where it was, it was sorta like you walk in the door - psych services was that way and dentist was that way so you could be going to the dentist when really you were going to psych services.* (Aisbett et al., 2007, p. 8)

Despite the advantages of co-location, King et al. (2006) note that there are significant barriers to its implementation in the Australian setting such as difficulties with coordinating federal and state funding, a policy setting that preferences separation, different philosophical underpinnings.

The alternative is to enhance intersectoral links, which involves *"… the establishment of formal communication structures to enable collaboration and sustained communication between vocational and clinical services, supported by formal protocols and regular cross-training*" (King et al., 2006, p. 475). Vocational and mental health services are kept separate and *"integration is achieved through the allocation of case-based funding places to the health service's outpatients, supported by cross-training and service protocols that emphasize frequent and effective communication"* (King et al., 2006, p. 476). The disadvantages raised by King et al. include the extra time and energy required to maintain communication and to ensure integration of consumer health-care and vocational plans. King et al. also suggested the need for additional quality assurance mechanisms to maintain high-quality linkages.

7.6. SUSTAINING WORK

There is substantially less research on sustaining work compared to gaining entry to work. This is an area in need of further development.

7.6.1. WORKPLACE ACCOMMODATIONS/MODIFICATIONS

There is very little research conducted specifically into understanding the workplace accommodation or modification needs for people with mental health conditions, and even less so for young people.

MacDonald-Wilson et al. (2002) found the following workplace accommodations have appeared in studies, however, the studies were inconsistent in their use of definitions and categories and were difficult to generalise:

- **the need for flexible scheduling** (EEOC, 1997; Ellison & Russinova, 1997; Granger, Baron, & Robinson, 1996; Kirchner & Makowski, 1994; Fabian, Waterworth, & Ripke, 1993; Gallup, 1992; Mancuso, 1993, 1990; Zuckerman, 1993),
- **job modification or restructuring** (Kirchner & Makowski, 1994; Fabian et al., 1993; Zuckerman, 1993; Mancuso, 1990), facilitating communication on the job (Zuckerman, 1993; Mancuso, 1990),
- **modifying employee training** (Zuckerman, 1993; Parrish, 1991; Berkeley Planning Associates, 1982),
- **providing training to staff or supervisors** (Kirchner & Makowski, 1994; Berkeley Planning Associates, 1982),
- **modifying supervision** (EEOC, 1997; Granger, Baron, & Robinson, 1996; Kirchner & Makowski, 1994),
- **making policy changes** (EEOC, 1997; Parish, 1991b),
- **modifying the physical environment or providing special equipment** (EEOC, 1997; Kirchner & Makowski, 1994; Gallup, 1992; Mancuso, 1990),
- **changing work procedures** (Granger et al., 1996; Kirchner & Makowski, 1994; Berkeley Planning Associates, 1982).

Other studies have reported that direct costs for workplace accommodations for people with psychiatric disabilities are not expensive, ranging from 90% of accommodations costing less than US$100 (Granger et al., 1996) to nothing in direct costs (Fabian et al., 1993). However, there is acknowledgement that there may be indirect or hidden costs as a result of accommodations.

7.6.2. EMPLOYEE ASSISTANCE PROGRAMS (EAPS)

Employee Assistance Programs (EAPs) is a commonly used term for workplace counselling programs often facilitated by an external organisation to ensure independence and confidentiality. A systematic review of workplace counseling (Henderson et al., 2003), which identified more than 80 studies, reported that "… after counselling, work related symptoms return to normal in more than half of all clients, and sickness absence is reduced by over 25%; that workplace counselling is an effective treatment for anxiety, depression and substance misuse as well as 'stress'. It is claimed that such results can be produced by as little as three sessions of any style of counselling as they all turn out to be effective" (p. 899). However, a further analysis of the studies questioned this finding and found that the evidence was not sufficiently rigorous, nor was there adequate appraisal of potentially adverse consequences.

7.6.3. PROMOTING MENTAL HEALTH IN THE WORKPLACE

The workplace has been identified as an important setting for promoting positive mental health and wellbeing and preventing mental health problems (European Agency for Safety and Health at Work, 2011). Mental health promotion programs can be aimed at either an individual or organisational level (or both). Typically, activities aimed at the individual level seek to increase

emotional resilience and give individuals the skills to deal with potentially harmful working conditions (European Agency for Safety and Health at Work, 2011; Corbière et al. 2011) while interventions aimed at the organisational level aim to improve the working conditions, working environment and levels of social support (European Agency for Safety and Health at Work, 2011; Corbière et al. 2011).

The European Agency for Safety and Health at Work (2011) report that "*interventions that solely target changing individual behaviour are not particularly effective for the individual or for the organisation".* However, a systematic review by LaMontagne et al. (2007) found that job-stress interventions that were individually focussed favourably affected individual-level outcomes but tended not to have favourable impacts at the organisational level.

Both LaMontagne et al. (2007) and Corbiere et al. (2011) suggested that initiatives that intervene at both the individual and organisational level are more effective than those which only intervene at the individual level. However, Corbiere et al. (2011) expressed that organisations have a tendency to favour individual interventions, as they are less resource-intensive and generally easier to implement.

7.6.4. SUPPORTING EMPLOYERS

Lloyd and Waghorn suggest that there needs to be support provided to employers and that workplace education programs can help:

> "*Ongoing support to employers may influence their hiring decisions positively. It is essential to educate employers about mental illness, address their fears and ignorance and ensure that they feel supported in their role of managing employees with psychiatric disabilities (Shankar and Collyer 2003, Shankar 2005). This is best approached by providing a workplace education programme rather than focusing specifically on individuals. Such a programme could include the topics of mental health in the workplace, managing stress and positive working relationships (Waghorn and Lewis 2002). In addition, facilitating communication between the employer and the person through routine workplace interactions is likely to help to reduce any stigma associated with inaccurate beliefs about psychiatric disabilities (Waghorn and Lewis 2002).* (Lloyd & Waghorn, 2007, p. 54-55)

7.7. SUPPORTING THE TRANSITION BETWEEN EDUCATION AND WORK

7.7.1. ADDRESSING DISENGAGEMENT

The OECD (2010), in its *Jobs for Youth* report, conducted a synthesis review on programs addressing youth engagement in a number of countries, found that successful programs appear to share the following characteristics:

- *Outreach programmes together with early intervention and profiling involving all the responsible stakeholders are crucial. Appropriate co-operation should exist between the PES [Public Employment Service] and the education system to reach youth as soon as possible when a risk of them dropping out of school is detected. For example, referrals from schools to the PES are essential if dropping out of school is to be addressed at the earliest opportunity when success is most likely. Youth outreach programmes should identify and contact disconnected NEET youth and not just school-leavers who cannot find a job. All jobless youth should be encouraged to register with the PES, where a profiling process should be implemented quickly to determine who is jobready and who should be involved in re-employment or more comprehensive programmes.*

- *Good programme-targeting is important. For example, there is a need to distinguish between teenagers and young adults and to focus on school drop-outs. Specifically, the most desirable solution to the employment problems of teenagers is to help them*

remain in school and acquire useful qualifications, whereas for young adults, help to get work experience is more important.

- *Tight job-search requirements and mandatory participation, in ALMPs [Active Labour Market Programs], backed by the threat of moderate benefit sanctions tend to "encourage" early exit from unemployment to a job and prevent long-term exclusion. Young people without sufficient work experience are generally not entitled to unemployment benefits. During a period of crisis, unemployment insurance eligibility could be expanded to better cover young workers and access to social assistance could be extended for those youth who risk marginalisation. However, this should be coupled with a rigorous "mutual obligations" approach based on an effective mix of so-called "carrots" (income support and effective ALMPs) and "sticks" (activation stance and moderate benefit sanctions).*

- *In terms of the mix of ALMPs, job-search assistance programmes are often found to be the most cost-effective for young people who are assessed as ready to work, providing positive returns to both earnings and employment. During a crisis, it is essential that access to appropriate job-search assistance measures is provided by the PES in the first weeks of unemployment. A shift from a "work-first" approach to a "learn/train-first" approach could be considered for those who have had major difficulties in finding a job. Such a shift could be especially appropriate during an economic downturn when the opportunity cost of time spent on a training programme or in education is lower. While it would be important to include an on the-job component to learning and training programmes, public-sector jobs could also be offered temporarily to disadvantaged youth so that they acquire skills that would be transferable to private sector jobs and hence enhance their chances of finding a job when the economic recovery strengthens.*

- *In addition, programmes that integrate and combine services and offer a comprehensive "package" seem to be more successful. As an example, job-search assistance programmes should include not only workshops to learn how to write a resumé and contact potential employers, but also mobility and housing assistance.*

- *Comprehensive programmes including adult mentoring, work experience and remedial education may yield positive returns, particularly for the most disadvantaged youth.* (OECD, 2010, p128-9)

7.7.2. CAREER COUNSELLING

Lloyd and Waghorn (2007, p. 56) recommend that:

"Career counselling can be brief and exploratory and can occur in parallel with more active forms of vocational assistance (such as job searching) in order to build on a person's current motivation and job preferences, while not delaying attainment of the primary employment goal (Bond 2004). Waghorn et al (in press–b) suggested using a multidimensional measure of socially valued role functioning in the early stage of vocational assistance. This measure is expected to help individuals in reviewing current role activities and in selecting opportunities within available role options. For instance, a person may express employment interest yet, when asked about other role activities, may reveal an existing ongoing commitment to care for children or an ageing person, an equally important role that may not currently allow sufficient time or energy to be diverted to vocational goals."

7.7.3. INTERMEDIARIES

In a study of innovative responses to labour market disadvantage in vocational education (VET), Bretherton (2011), categorised barriers to labour market participation in two ways:

- a state of information asymmetry, whereby those not in the labour force lack information about employment and options for accessing employment

- a compromised state of labour market readiness, whereby those job seekers who are marginalised by the labour market are less ready to undertake employment.

Bretherton argued that labour market intermediaries can play an important role in addressing these barriers and consequently, labour market disadvantages and thus create better participation pathways. The author identifies three innovative strategies utilised by intermediaries:

- **Networking**: Innovative agencies exhibited a tendency to network and form ongoing and purposeful links with other agencies within their respective labour markets. This enabled a meaningful and regular exchange of information about clients and client progress and allowed agencies to collaborate in order to source and fill gaps in the support network for their clients.

- **Adaptation**: Innovative labour market intermediaries adapt, and strategically position themselves to continually adapt, in order to meet the needs of disadvantaged job seekers. This adaptation incorporates changes to both content and/or delivery of training to better meet student, worker and labour market need.

- **Reinvention**: A third and more radical innovation undertaken by intermediaries is to reinvent the organisation in order to provide the substantial services that may have been undertaken by other operators in the field. Reinvention represents innovative behaviour in the context of social welfare and employment service providers since, historically, the practice of referral has formed the basis of much intermediary behaviour. In other words, if a client required an additional support prior to seeking transition to the labour market, they were previously referred to other agencies better resourced to meet this need. Reinvention is important because it offers agencies greater scope to provide for, or fill gaps, in the existing suite of essential services available to disadvantaged job seekers and workers.

Bretherton suggested that *"VET by itself is not necessarily enough to enable transitions to employment for marginalised groups. For disadvantaged groups, social and economic supports are needed for them to be able to make the most of VET."*

7.7.4. MENTORING

7.7.4.1. Definitions of Mentoring

While there is a lack of consistency in definitions of mentoring, there is general acceptance that traditional concept of mentoring involves a more senior or experienced person providing "various kinds of personal and career assistance to a less senior or experienced person" (Haggard et al., 2010). In the Australian policy context, this is most often defined by governments as "a mutually beneficial relationship that involves a more experienced person helping a less experienced person to achieve their goals" (Australian Government, 2010).

A variety of taxonomies have been produced to categorise mentoring. One dichotomy views mentoring is as either formal or informal where formal mentoring is structured and organised while informal mentoring derives from relationships that arise naturally. Formal mentoring programs vary widely in their "nature, focus, and outcomes" (Ehrich et al., 2012) and may include training of mentors or not, different methods of selecting mentors or mentees, and different levels of organisation (Jacobi, 1991). Corney and du Plessis (2010) define formal mentoring as involving an "artificially constructed, classical, deficit-based mentoring "program"" while informal mentoring "utilises the supportive networks formed naturally by young people in their work or training context" and is often strengths-based. It should be noted that as with the general definition of mentoring, the formal/informal distinction is not precise (Wanberg et al., 2003; Haggard et al. 2010). While formal mentoring may often be deficit-based and hierarchical as Du Plessis and Corney have argued, it need not be. What is key however, is that they are constructed, usually with some organisational purpose, through what Sosik and Godshalk (2000, in Haggard et al., 2010) termed "deliberate pairing" and have not come about naturally.

Broader definitions of mentoring have developed to encompass multiple sources or what Kram (1985) influentially described as networks of developmental relationships. For example, Eby, Rhodes, and Allen (2007) viewed mentoring differentiated from other developmental relationships such as the teacher/student, supervisor/subordinate, coach/client relationships. Du

Corney and du Plessis (2010) in their research on young apprentices' support relationships noted that apprentices identified " … a range of mentors in their lives, predominantly in their personal lives, and that the majority of these relationships develop organically" and recommended that the definition of who is a mentor is expanded to include "significant others". Raabe and Beehr (2003) note that there has been a shift away from having older, more experienced mentors paired with younger, less experienced mentees to other alternative models of mentoring that include "peers, groups, and even subordinates." McManus and Russell (2007, in Holland, 2009) found that "repeatedly, researchers have suggested that individuals who have multiple sources of support fare better than those who do not."

Peer mentoring is when a person's peers perform mentoring roles, rather than a superior. This can involve more experienced peers mentoring those who are less experienced (Godshalk & Sosik, 2003 in Haggard et al. 2010) or equal peers as mutual mentors (Eby et al., 2000 in in Haggard et al. 2010). Haggard et al. (2010) notes that these peer mentoring relationships can be more reciprocal and involve a two-way exchange rather than one where there is more of an experience gap, with the result that "Peers can be a strong source of social support and friendship but typically do not have the organizational power to enhance one's career progress." Peer relationships can be as a result of natural pairings (Corney & Du Plessis, 2010) or they can be formally organised. Holland (2009) also differentiates peer mentoring from "distributed mentoring" where "designated mentors are often assisted by 'helpful others' (Eraut, 2007).

A further concept is that of "reverse mentoring" (originally Greengard, 2002) is noted by Haggard et al. (2010) where "reverse mentoring, although also a reciprocal relationship, is formed with the intent that the protégé provide developmental assistance to the mentor, usually involving the use of technology and/or the sharing of information and knowledge."

7.7.4.2. Assisting the transitions into work

The main focus in the workplace mentoring literature has been on career-orientated goals, with psychosocial support often being referred to as "pastoral care" (Fattore et al., 2012). However, there is growing overlap and interchangeability of these terms as the value of psychosocial support is increasingly recognised in mentoring, especially for its potential to help youth through the critical school to work transition period.

There are clear links in the literature between psychosocial factors and career and learning outcomes (Kram, 1985; Burgess & Dyer, 2009). Personal and psychological issues are frequently cited as a main reason why young apprentices do not complete training. Ainley et al. (2005) found that "Reasons given for not continuing a New Apprenticeship most frequently focussed on personal issues such as dislike of the type of work, getting along with supervisors or others at work, being offered a better job or feeling that the pay was too low. The difficulty of study, future job prospects or the nature of the on or off the job training were not key reasons for discontinuing a New Apprenticeship."

Du Plessis and Corney (2011) highlighted the vulnerability of young Australian men and their heightened risk of suicide and identifying the importance of support during the transitional period between school and work. They asserted that the "support systems available to apprenticeships are of particular importance in assisting them to successfully negotiate these transitions and successfully complete their apprenticeships." Corney and du Plessis (2010) note that "Mentoring relationships have been found in some contexts to be valuable in improving self-esteem and reducing rates of risk-taking behaviours in young people (Moodie 2005)… The provision of mentoring relationships for young men could offer a viable form of support within the vocational training process, which in turn could assist in increasing apprenticeship completion rates (Dowling et al. 2005)."

Fattore et al. (2012) suggested that mentoring could assist in helping young people develop the 'work readiness' needed to transition from school into the world of 'adult work'. One respondent noted:

> *They've [young commencing apprentices] come from school to work and it's a whole different set of rules and behaviours and expectations. They may have gone from - or they may still have parents at home, doing their washing and ironing for them. Yet, now they're in the work place expected to do dirty work. So I see a role of a mentor there*

having conversations about that. About how it is to do all kinds of work and be respected for that too. (p. 16)

7.7.4.3. Risks of Mentoring

Erich et al. (2004) makes the observation that most of the mentoring literature focuses on the resulting benefits. One of the exceptions to this generality is Long (1997) who claims that "… under various conditions, the mentoring relationship can actually be detrimental to the mentor, mentee or both". Erich et al. summarises Long's concerns as " …. a lack of time for mentoring, poor planning of the mentoring process, unsuccessful matching of mentors and mentees, a lack of understanding about the mentoring process, and lack of access to mentors from minority groups." Freedman and Baker (1995) make the observation that "mentoring relationships are often complex and delicate vessels, requiring some care even when they occur naturally" and then go on to note that "when put together poorly, mentoring efforts can actually do harm - reinforcing stereotypes on the part of adults and providing young people with alienating experiences in the workplace." Holland (2009) referred to the work of Boud et al. (2009) that found evidence that formalising developmental relations can change what was previously an enjoyable "… experience of governing their [the workers'] learning through informal learning connections … " to " … a sense that they are being governed by others and are under surveillance." Holland goes on to highlight the importance of the mentor/mentee matching process and that an " … undemocratic process can create resistance in trainees. While Billett's (2003) research found generally positive results, he also noted that some mentees "faced belligerence from those whom they were mentoring. Others may well have been sources of hostile relations with co-workers… other mentees resisted or were affronted by the mentoring process, claiming to be more knowledgeable than their assigned mentors."

7.7.4.4. Barriers to work-based mentoring

Dumbrell (2006) notes that the "ACIRRT (2002: 33-38) study of Victorian manufacturers found that as a result of reduced employment, the intensity of work in the remaining workforce had increased to the point where there was simply no surplus labour capacity to disengage experienced tradespersons from production to train and mentor apprentices… Employers also reported that intensified competition and tighter margins had reduced their financial capacity to invest in the level of training that they would like." Some employers may also just be too small to be able to afford and manage the provision of mentoring (Cully and Curtain, 2001). More broadly, Billett (2003) notes that "workplace factors associated with the intensity of the existing workload, shortage of staff, and the demands on other workers" are key constraints that inhibit mentoring within organisations.

7.7.4.5. The role of intermediaries in providing work-based mentoring

Cully and Curtain (2001) suggested that intermediary organisations such as group training providers can deliver support to small employers that are unable to provide on-site mentoring. This support " … could be delivered via telephone or through on-site counselling for new apprentices… Mentoring assistance could include help with induction training, and information on the competences required of the coaching role expected of a work supervisor." Other forms of support could also include: " … assistance with developing a training plan, seeking ways to better integrate off-the-job training with on- the-job training, seeking feedback from new apprentices on the quality of both the on-the- job training and acting as a go-between where there is evidence of poor practice." They give an example of a mentoring program put in place by a training provider for a large service station chain where each trainee was allocated a mentor who was generally off-site. In addition to the apprenticeship mentoring, it was found that special night time events where parents can attend and meet the mentors were very successful.

According to Dumbrell (2006), "Group training companies have taken up much of the slack in training supply caused by the decline in government enterprise and utilities' training provision… Group training companies, for example, carry out strict screening processes which affect employment outcomes. With a prime focus on job placement, they trade on the excellence of their graduates in terms of skills, attitudes and overall job readiness. They said that the

student's attitude is of prime importance. They are very strict on attendance and behaviour of the students and provide substantial support to nurture these aspects of a student's development." In comparison, Dumbrell found that "TAFE colleges on the other hand, [were] not structured to deliver the same level of pastoral care and placement activities."

Clarke and Lamb (2009) highlighted the need to manage the continued provision of pastoral support to out-of-trade and stood down apprenticeships. As group training organisations can provide continuous relationships for apprentices through changes in employers, they are in the prime position to ensure that this group of apprentices receives continued mentoring support.

Snell and Hart (2007) note that there was the view that organisations such as group training organisations should better ensure that employers fully understand their role and responsibility in regards to training. There was the feeling that training needed to be provided to the employer as well as the apprentice. As one government representative stated: *"I think the group training organisations . . . need to be spending more time with employers in helping to train them on how to receive and mentor an apprentice"*. On the other hand, Snell and Hart note that other scholars such as Schofield (2001) take a more skeptical approach with the view that "there will continue to be some employers who place training as a low priority" and "that cost, rather than quality can often drive the training choice".

8. SUPPORTING THE INDIVIDUAL

8.1. DISCLOSURE AND STIGMA

Disclosure is often a precursor for young people to receive assistance related to a mental health condition in educational or workplace settings. However, this can be incredibly problematic as disclosure of mental health related information can be a particularly sensitive issue. This is rarely sufficiently recognised by those who would seek to provide help.

8.1.1. DISCLOSURE AND EDUCATION

Venville and Street (2012) in their study of student perspectives on disclosure of mental illness in VET found observed that "for students, the decision to disclose or not disclose their mental illness is difficult… Students spoke of the fear of further stigma, prejudice and rejection". Students did not feel that disclosure was a choice but instead "the act of disclosure is perhaps best understood as an act of desperation or obligation" with fear of failing courses being a major reason to disclose.

Yet, institutional support was predicated on disclosure. The researchers reported that "most staff members expected students to disclose their illness" with reluctance being seen as unwillingness "to be responsible and work with staff to ensure their educational success." It was also reported that staff felt that there was enough training to support students with mental health conditions.

The research found that support services could improve outcomes for students who did disclose and equity and specialist staff reported placing a high level of trust in the institution to support students who disclosed, yet when "asked if they would disclose their own mental illness or encourage a colleague to do so, all staff indicated they would 'probably not'. What appeared to be trust in the organisational response to students with a mental illness was in reality a trust in their own response. The organisations, it seems, did not inspire the requisite trust for voluntary disclosure by staff. Interestingly, the staff we interviewed did not seem to recognise this tension."

The researchers noted that disclosure did not necessary result in appropriate help for the student. In some instances, a number of students had thought the indication of their disability status on enrolment forms constituted disclosure which would result in immediate help. Unfortunately, it did not. Others report disclosing but not receiving appropriate or helpful support.

Students also reported difficulties in disclosure that were related to their illness: "Students stated that the time they most need help from others is invariably the time when they are least able to seek, request and accept assistance." In the words of one student interviewed:

> *Part of the depression that I have, is I, I can't make friends. I mean I have a very hard time of opening to other people and making other people at the course feel comfortable with me ... I find that I feel not confident, not comfortable but I just don't want to talk to other people ... and I find that sometimes I won't talk to the teachers and when I need something, I don't actually ask for it ... let's say I have to make an appointment with someone, or have to go and see the teacher, I'm putting it off, as much as I can. It's not because I want to put it off, it's just that I'm not ready to face that person and talk to them and it, it's very hard to explain that to other people because it's not because you don't want to ask for help, it's not because you don't want to talk about it, it's just you can't do it, now, you have to put it off.*

Venville and Street recommended a number of changes to improve support for students with mental health conditions: including proactively monitoring student performance and reaching out to students who are disengaging; providing multiple opportunities for students to accept help; and putting more emphasis on support rather than on the condition (for example changing the enrolment form to ask whether a student needs "study support" rather than "do you have a

disability?"); and offering support and reasonable adjustment to all students, not just those with a disability.

Similar issues are found in tertiary institutions. Fear of stigma was found to be the biggest barrier to help seeking in the 2012 *College Students Speak* survey published by the US based National Alliance on Mental Illness (NAMI). The survey found that only half of the respondents had disclosed their illness to their educational institution.

The top five reasons given why students disclosed were:

- To receive accommodations.
- To receive clinical services and supports on campus.
- To be a role model and to reduce stigma.
- To educate students, staff and faculty about mental health.
- To avoid disciplinary action by the school and to avoid losing financial aid.

The top five reasons given why students did not disclose were:

- Fear or concern for the impact disclosing would have on how students, faculty and staff perceive them, including within mental health degree programs.
- There is no opportunity to disclose.
- The diagnosis does not impact academic performance.
- Do not know that disclosing could help secure accommodations.
- Do not trust that their medical information will remain confidential.

NAMI provided the following recommendations on disclosure:

- Give willing students opportunities to reduce stigma and to educate others about mental health.
- Support programs that eradicate stigma on campus and help to make students more comfortable with disclosure.
- Make school policies on confidentiality and privacy visible and easily understood by all.
- Educate the entire campus community on mental health issues to eliminate the myths and stereotypes that make students uncomfortable with disclosure.
- Target mental health degree programs with stigma-busting activities to reduce the fear and concerns of students in these programs.
- Provide resources on the pros and cons of disclosure so students can make an informed decision about disclosing.

8.1.2. DISCLOSURE IN THE WORKPLACE

Two reviews of the literature on workplace disclosure of mental illness found mixed results. While disclosure could result in workplace accommodations and improved support, it could also result in discrimination and stigma.

Brohan et al. (2012) in a systematic review found the following themes for reasons for non-disclosure in the workplace:

- wouldn't be hired if disclosed
- unfair treatment in the workplace
- would lose credibility in eyes of others
- legislation does not provide protection
- gossip

- rejection

- passing (that is, the person was able keep the illness concealed)

- illness as private (that is, "the belief that information about mental illness is deeply personal and too intimate to share with individuals in a workplace")

- job with natural adjustments (for example, a job that offered the flexibility to work at home)

- others don't want to know ("the belief that people do not want to talk about mental illness and that telling others is a source of burden to that person.")

Brohan et al. found the following themes for reasons for disclosure:

- role model for others ("beliefs that disclosure allows a person to educate others about mental illness and to be a role model for other individuals who are in a similar situation")

- to gain adjustments (and conversely, the literature search found evidence of the belief that if no adjustments are needed, then it was best not to disclose)

- positive experience of disclosure;

- to obtain emotional support (as opposed to formal workplace adjustments)

- to be honest ("beliefs including fear that lack of honesty could lead to dismissal as well as wanting to be proud of one's identity as a person with a mental health problem")

- to explain behaviour

- stress of concealing ("The experience of constructing a 'cover story' to explain unusual behaviour is described as a source of shame and an energy draining activity").

Brohan et al. (2012) found that the majority of evidence supported the notion that "disclosure of a mental illness places job applicants at a disadvantage in securing employment compared to applicants with a physical disability or no disability.

In reviewing the literature, Jones (2011) found that reported disclosure rates range from 35% to 87% with the differences "most likely result from the variety of study populations, data collection methods, and data analysis techniques employed by the studies". Jones concluded that (p. 226):

> "*workers considering disclosure must balance their needs for accommodations and interpersonal support against the possibility of stigmatizing reactions and interpersonal problems at work. If they choose to disclose, these workers can consider all disclosure characteristics as they develop individualized disclosure strategies that maximize the potential for benefits and minimize the probability of negative reactions or outcomes.*"

There is extremely little work conducted specifically on the workplace disclosure experiences of young people with mental illness.

8.2. ACCESSING MENTAL HEALTH SERVICES

A systematic review (Gulliver et al., 2010) of the barriers and facilitators of mental health help-seeking in young people found that studies indicate that "approximately 18 to 34% of young people with high levels of depression or anxiety symptoms seek professional help."

Guilliver et al. found the following themes to the barriers from their analysis of the qualitative literature:

- Public, perceived and self-stigmatising attitudes to mental illness

- Confidentiality and trust

- Difficulty identifying the symptoms of mental illness

- Concern about the characteristics of the provider

- Reliance on self, do not want help

- Knowledge about mental health services

- Fear or stress about the act of help-seeking or the source of help itself

- Lack of accessibility, e.g., time, transport, cost

- Difficulty or an unwillingness to express emotion

- Do not want to burden someone else

- Prefer other sources of help (e.g., family, friends)

- Worry about effect on career

- Others not recognising the need for help or not having the skills to cope

The following facilitator themes were found from the few studies that identified facilitators:

- Positive past experiences with help-seeking

- Social support or encouragement from others

- Confidentiality and trust in the provider

- Positive relationships with service staff

- Education and awareness

- Perceiving the problem as serious

- Ease of expressing emotion and openness

- Positive attitudes towards seeking help

Gulliver et al. were unable to find any quantitative studies that identified facilitators. The seven quantitative studies identified the following barriers:

Table: Top rated barriers by quantitative studies (n = 7) (Gulliver et al., 2010)

Author	Top rated barriers
Sheffield (2004)	School counsellor 1. Prefer to handle myself (45%) (self-reliance) 2. Don't think they can help (27%) (no one can help) Doctor 1. Too expensive (25%) (cost) 2. Prefer to handle myself (23%) (self-reliance) Psychologist/Psychiatrist 1. Too expensive (50%) (cost) 2. Don't know where to find (28%) (knowledge)
Dubow (1990)	1. I felt that no person or helping service could help (55%) (no one can help) 2. The problem was too personal to tell anyone (53%) (stigma/comfort)
West (1991)	1. I do not like to tell a stranger about personal things (29.4%) (stigma/comfort) 2. I am afraid counsellor will pass information about me to other people (18.3%) (confidentiality)

Kuhl, (1997)	1. If I had a problem I would solve it by myself (3.87) (self-reliance)
	2. I think I should work out my own problems (3.79) (self-reliance)
Wilson (2008)	1. I feel comfortable talking to a GP (general practitioner) who I don't know (1.65) (stigma/comfort)
	2. I'm not embarrassed to talk about my problems (1.51) (stigma/comfort)
Eisenberg (2007)	1. Stress is normal in graduate school (51%) (self-reliance)
	2. Have not had any need (45%) (no perceived need)
Brimstone (2007)	1. Worries about either knowing the doctor/counsellor or having to have future dealings with the counsellor/ psychologist or general practitioner at university health care centre (stigma/comfort)
	2. Worries about either knowing the doctor/counsellor or having to have future dealings with the counsellor/ psychologist or general practitioner at non-university health care centre (stigma/comfort)

A recent survey of US college students with mental health conditions identified a range of reasons for what made on-campus clinical support good and what made it poor.

Table: US college students explain why you found your college's services and supports good or poor (NAMI, 2012).

Top five reasons students found services and supports good	Top five reasons students found services and supports poor
There is effective coordination between students, treatment providers, professors and the DRC [Disability Resource Centre].	There are a limited number of counselling visits allowed on campus and a limited number of resources.
There is free group and individual counselling offered on campus.	There are not enough adequately trained mental health providers.
There is variety and flexibility. Help is available 24 hours a day, seven days a week.	The college does not recognise the importance of peer support.
There are permanent, qualified and caring mental health staff members, including on-site psychiatrists.	There is a lack of communication between mental health providers and others involved in students' care.
There are supportive students, faculty and staff who participate in mental health groups and training.	The college is too quick to prescribe medications or hospitalise students with mental health issues.

8.3. ESPECIALLY VULNERABLE GROUPS

It is recognised that while each young person is an individual, certain groups of young people may be especially vulnerable in the transition from school to work, for example young people who are:

- **from culturally and linguistically diverse backgrounds**:
  - The literature suggests that young people from linguistically and culturally diverse backgrounds may be at risk of heightened psychosomatic symptoms, low self-esteem and identity confusion (Queensland Transcultural Mental Health Centre 2001 in DOHA, 2004), however other studies show that culturally and linguistically diverse young people's voluntary use of mental health service is lower than that of other communities, with suggested reasons including

language and cultural barriers, lack of information on services, stigma and parental suspicion of youth services. (DOHA, 2004)
- o Refugee young people can be at particularly high risk for mental distress. According to DOHA (2004), "*Studies suggest these young people experience an increased incidence of mental illness, often including comorbid depression, anxiety and post-traumatic stress disorder (Bevan 2000).*"

- **Aboriginal or Torres Strait Islander:**
  - o DOHA (2004) state that "*Any consideration of mental health in Indigenous communities needs to be placed within a social and historical context (Brady 1991). Aboriginal and Torres Strait Islander peoples' traditional holistic understanding of health, incorporating the physical, social, emotional and cultural wellbeing of the whole community, complicates the measurement of mental health. Further, there has been little agreement on how such measurement should be done (Edwards & Madden 2001). The Australian Bureau of Statistics (Edwards & Madden 2001) found that: Data on self-harm, child abuse and neglect, substance misuse and incarceration indicate that Indigenous people suffer a higher burden of emotional distress and possible mental illness than suffered by the wider community.*"

- **physically or intellectually disabled**
  - o *Systematic study has shown that people with an intellectual disability are at risk of developing any of the full spectrum of mental disorders experienced in the general population (Szymanski 1994, cited in Curran et al. 2000). Psychotic disorders are frequently overdiagnosed, while anxiety and mood disorders tend to be underrecognised. Specific syndromes of intellectual disability may also lead to personality profiles, psychiatric disorders and/or behavioural patterns that are associated with the individual syndrome (Curran et al. 2000).*(DOHA, 2004)

- **gay, lesbian or transgender:**
  - o *The Christchurch longitudinal cohort study, which has published data on young people up to the age of 21 years, found that young people who identify as gay, lesbian or bisexual are up to six times more likely than young people who identify as heterosexual to have a range of mental health problems and mental disorders, including depression, anxiety, conduct problems, substance abuse and suicidal behaviours (Fergusson & Horwood 2001).* (DOHA, 2004)

- **substance abuse disorder:**
  - o *Mental health disorders are common in young people with a substance use disorder, and substance use problems are more common among those diagnosed with mental disorders than among the general population (Hambrecht & Hafner 1996, cited in Commonwealth Department of Health and Aged Care 2000c; Jablensky et al. 1999; McLennan 1998).* (DOHA, 2004)

- **homeless**:
  - o *Reilly et al. (1994) found a high incidence of depressive illness and substance use disorders among homeless young people, but a low rate of service use by this group, highlighting the need for mental health professionals and other agencies to interact more closely in planning and providing services for these young people.* (DOHA, 2004)

- **In the criminal justice system**:
  - o There is little no accurate national data exist on the prevalence of mental disorders among young people in prisons, a NSW report (Butler et al., 2003 in DOHA, 2004) found that the level of mental health problems and disorders is three to four times higher among inmates compared with the general Australian population.

- **living in rural and remote areas**:
  - o Aisbett et al. (2007) noted that little work had been done on young people with mental illness in rural communities, however, studies on adults have found that there are a number of disadvantages faced included access issues (both in terms of cost and travel distance required) and a lack of qualified mental health professionals in rural and remote areas. Aisbett et al. also highlight that the "'rural paradox of proximity and distance' often are the silencing of mental health difficulties" through stigma, discrimination and lack of confidentiality.

- **international students**:
  - Forbes-Mewett and Sawyer (2011) found that international students had a tendency to delay professional help-seeking for mental health problems. This tendency along with the "experience of new and often unfamiliar academic practices" and "broad range of knowledge and practical skills needed to manage day-to-day living in Australia" appeared to heighten the stresses and strains experienced by international students.

9. FLEXIBLE SUPPORT FRAMEWORKS

The emerging literature is very clear on the importance of flexibility in supporting young people with mental illness in the transition from school to work. The research into disclosure and the consequences of non-disclosure demonstrates that young people in distress often need multiple opportunities for help and there is no 'one size fits all'.

The literature on how to effectively provide strong structures of support for youth across the school to work transition is developing and many gaps remain. In order for support structures to be flexible and adaptive, there needs to be feedback mechanisms. Across the diverse topics covered in this literature review, there is a notable lack of research that asks young people with mental illness what has been their experience and what do they want.

Strength based approaches are participatory and engaging. Following a strength based approach, the Working Group that produced the *Responding to the Mental Health Needs of Young People in Australia, Discussion Paper: Principles and Strategies* (DOHA, 2004) developed the following set of principles for service provision for young people to better deliver their needs:

- **Accessibility and engagement:** Services should be accessible to all young people who need them, across cultures, language groups, communities of place and interest, abilities and socioeconomic groups. Similarly, mental health services should actively engage relevant groups of young people within the community.
- **Consumer and carer involvement:** The involvement of young people and their families should occur in all aspects of service policy, planning, delivery and evaluation.
- **A preventative approach with a recovery focus:** Expertise should be developed in these areas using a sound evidence base, to provide new opportunities for preventing mental illness and/or minimising or containing its effects in the short term and throughout adult life.
- **Continuity of care:** A continuum of service provision should occur across the service system, and through young people's developmental transitions.
- **Workforce and workforce performance:** A suitable range of workers needs to be available, with an appropriate range of professional expertise, an understanding of the issues facing young people, and the ability to exchange skills and expertise across a team.
- **Quality and performance:** The provision of care of assured quality is required of all health services (DOHA, 2004)

9.1. ADDRESSING SYSTEMATIC ISSUES

While this review addressed the direct support mechanisms to assist young people with mental illness in their transition from school to work, the literature supports the existence of broader systematic effects on young people's mental health and their capacity to participate. For example, poverty and lower SES has been linked with higher rates of mental illness in children and adolescents. Similarly, labour markets can operate to systematically and unfairly exclude groups of willing workers and channel others into low quality and precarious work, which limit opportunities for growth (Schmid, 1995) and may have negative health effects (Bohle et al., 2004). A focus on the more immediate sites of change should not also divert attention from broader reform to promote fairer, more inclusive societies.

10. AUSTRALIAN GOVERNMENT POLICIES

10.1. IMPROVING YOUTH TRANSITIONS

National Partnership on Youth Attainment and Transitions

In July 2009, The Council of Australian Governments (COAG) agreed to the *National Partnership on Youth Attainment and Transitions* (the National Partnership). The National Partnership has been allocated $608 million, plus up to $100 million in reward funding to states and territories for meeting targets, to support two main goals:

- to increase the amount of young people completing their Year 12 or equivalent qualification
- to halve the gap in young people completing year 12 or an equivalent qualification between Aboriginal and Torres Strait Islander peoples and non-Aboriginal and Torres Strait Islander peoples within ten years

The National Partnership includes the following programs:

- *Youth Connections* ($288million), which supports young people at risk of not completing Year 12 by helping them to remain engaged, or to re-engage, in education or training
- *Schools Business and Community Partnership Brokers* (Partnership Brokers) ($183million), which is focused on building whole-of-community partnerships to help young people to achieve Year 12 or equivalent qualifications and reach their full potential
- *Compact with Young Australians* ($30 million), which promotes gaining skills and ensures young people are learning or earning
- *National Career Development* initiatives ($106million), such as the myfuture website, Job Guide and the development of a *National Career Development Strategy*
- Project funding for states and territories to help them expand and maximise their initiatives for career development, multiple learning pathways and mentoring.

Australian Apprentices Mentorship Package

The *Australian Apprenticeships Mentoring Package* (Mentoring Package) was announced by Australian Government on 10 May 2011. The Mentoring Package aims:to increase the retention rates of Australian Apprentices, particularly in the first 12 months of training, in order to improve completion rates and support the supply of skilled workers in sectors and occupations where there is a current or emerging skills need.

The Mentoring Package is made up of two grants programs: the Australian Apprenticeships Mentoring Program (approx. $80 million, 2011-12 until 2014-15) and the Australian Apprenticeships Advisers Program (approx $21 million, 2011-12 until 2012-13).

Australian Apprenticeships Mentoring Program funds organisations to implement targeted mentoring to help Australian Apprentices successfully progress through their Australian Apprenticeships. The aim of the Mentoring Program is to help Australian Apprentices successfully progress through their Australian Apprenticeships. Mentoring may also involve support to their employers or supervisors to encourage a positive employment relationship and better support for Australian Apprentices. The Mentoring Program is targeted to Australian Apprentices who may face barriers to participation. It is anticipated that mentoring projects may focus on the first year of training when Australian Apprentices are most at risk of withdrawing

from their Australian Apprenticeships, however this will depend on the needs of the cohorts targeted for support.

Organisations eligible to apply for funding include:

- Professional associations, industry bodies and other lead agents representing a consortia of employers

- Enterprises

- Employment-related service providers such as Australian Apprenticeships Centres

Australian Apprenticeships Advisers Program

The Australian Apprenticeships Advisers Program (the Advisers Program) funding supports: Australian Apprenticeships Advisers to provide industry or occupation specific information to potential Australian Apprenticeship candidates to help them make an informed decision in choosing the right Australian Apprenticeship pathway. The Advisers Program primarily targets school leavers. Projects under the Advisers Program could also provide information and resources to potential and existing employers of Australian Apprentices to support effective recruitment in that occupation or industry.

Industry-led partnerships involving, but not limited to, Industry Skills Councils, peak industry bodies and employer and employee associations, are eligible for funding.

Regional Youth Affairs Networks (RYANs)

Regional Youth Affairs Networks (RYANs) are an initiative of the Victorian government and supported by the Office for Youth to improve outcomes for young people in Victoria.

The aims of RYANs are:

- provide strategic advice to government on key issues for young people in Victoria

- provide a key means for communication and consultation between young people and the Victorian Government

- be an advocate for the needs of young people in local and regional strategy development, community strengthening activity and government policy

- engage young people where appropriate, or consolidate information from youth engagement activity across the region

- promote information sharing and collaboration among youth service providers.

RYANs connect community members, youth service providers, young people and all levels of government that have an interest in improving the lives of young Victorians, to provide advice and channels of communication and consultation between the Victorian Government and young people.

10.2. MENTAL HEALTH FOCUSED INITIATIVES

Australian Government's National Mental Health and Disability Employment Strategy

The National Mental Health and Disability Employment Strategy (the Strategy) was announced on 14 September 2009, with the aim to address the barriers that are faced by people with a disability and/or mental illness that make it harder for them to gain and keep work. The intention of the Strategy is to improve social inclusion and the opportunities for Australians with disability and mental illness to search, find and maintain employment.

Strategy elements include:

- $1.2b in employment services for people with disability, with the aim that these new Disability Employment Services will provide more personalised services for job seekers and more support to employers;

- The 2009/10 Budget committed $6.8m for a pilot program to assist 1000 people with disability in receipt of the Disability Support Pension to demonstrate their skills;

- The Australian Public Service Commission has been tasked with developing appropriate training and best practice for Australian Public Service agencies and managers;

- A new Employment Assistance Fund brings together resources from the Workplace Modifications Scheme and the Auslan for Employment program, with the aim of making it easier for employers, people with disability, and employment providers to access assistance;

- An Innovation fund that aims to help more people with disability into jobs by funding innovative projects that remove barriers to employment; and

- Continued development of a National Disability Strategy to increase the social, economic and cultural participation of people with disability.

Mental Health Capacity Building e-learning package

On 9 August 2012, the Australian government announced a Mental Health Capacity Building e-learning package (training package) to "help employment services assist people with mental illness to gain employment and to get the right help". The training package was developed by Department of Education, Employment and Workplace Relations (DEEWR) and intended for personnel who deliver the Disability Employment Service, Job Services Australia and Remote Jobs and Communities Program.

The training package consists of six modules which cover:

- mental health awareness – strategies for developing mental health literacy skills to identify job seekers with mental illness

- communication and engagement – communication and engagement strategies to engage with job seekers who have mental illness

- identification and management of barriers – skills to address barriers to employment and build employment related skills for job seekers with mental illness

- engagement and marketing strategies for potential employers – skills to engage with employers and market job seekers with mental illness

- strategies to maintain the job seeker's employment – highlight and address issues about maintaining employment for job seekers with mental illness, including employer issues, and

- how to collaborate and build partnerships – strategies to connect and collaborate with services and programs relevant to the people with mental illness.

Targeted Community Care (Mental Health) Program

The Targeted Community Care (Mental Health) Program (TCC) is part of a COAG agreement that commenced in 2006 representing Australian governments' approach to mental health, with an emphasis on improving the capacities of those living with a mental illness and their families and carers to improve their quality of life. Over five years to 2011 three major programs were rolled out as part of the Australian Government's Mental Health Reform Budget measures:

- Personal Helpers and Mentors (PHaMs)
- Mental Health Respite: Carer Support (MHR:CS)
- Family Mental Health Support Services ($117 million allocated since commencement)

Personal Helpers and Mentors (PHaMs)

The 2011-12 Budget saw an additional $154 million over 5 years allocated to PHaMs.

The Personal Helpers and Mentors (PHaMs) service is for people aged 16 and over, and:

- increases opportunities of recovery for people who are severely affected by mental illness
- uses a strengths-based recovery approach
- helps them with daily activities

PHaMs service providers provide wrap-around support to assist participants in their recovery. They do this by:

- helps participants to better manage their daily activities and reconnect to their community
- provides direct and personalised assistance through outreach services
- provides referrals and links with appropriate services such as drug and alcohol and accommodation services
- works with participants in the development of Individual Recovery Plans which focus on participants' goals and recovery journey
- engages and supports family, carers and other relationships, and
- monitors and reports progress against each participant's Individual Recovery Plan.

Mental Health Respite: Carer Support (MHR:CS)

The Mental Health Respite initiative (MHR) aims to provide alternate or supplementary care arrangements and family support to support carers and families maintain their caring role. It provides a range of flexible respite and family support options for carers of people with severe mental illness/psychiatric disability and carers of people with an intellectual disability.

Family Mental Health Support Services (FMHSS)

Many people with a mental illness experience their first episode before the age of 12 years. FMHSS seeks to provide the early intervention children need through non-clinical support offered by community services. FMHSS had $56 million allocated to it from 2007-2011, and the 2011-12 Budget allocated $61 million over a further five years to create an additional 40 New FMHSS (so-called as it now recognises the need to target children currently in or leaving out-of-home care) across the country. Its objectives are that:

- children and young people have improved emotional health and wellbeing
- children and young people are better able to manage the different aspects of their lives
- families and carers are able to get help to support their children and young people
- communities have a better understanding of, and response to, mental health issues that affect children and young people

FMHSS offers the following activities:

- intensive, long-term, early intervention support, based on a Family Action Plan, specifically for children and young people, and their families
- short-term information, referral and assistance for families
- community outreach and group work

10.3. DISABILITY FOCUSED INITIATIVES

Disabilitycare Australia

DisabilityCare Australia (formerly known as the National Disability Insurance Scheme (NDIS)) is the national disability insurance scheme initiated by the Australian government. The enacting bill was introduced into parliament in November 2012. The scheme is commenced rollout in July 2013 to selected sites, with more sites planned for 2014 and further expansion in 2016.

DisabilityCare Australia aims to support people with permanent and significant disability, their families and carers. It is intended to better fund individualised support for people with disability to provide more choice and control, recognising the importance of a lifetime approach to a person's support needs. There is stated support for early intervention, where early intervention can reduce later costs.

DisabilityCare Australia will work with those who are eligible to:

- discuss individual goals and support needs

- develop an individual plan that will help achieve identified goals

- consider the supports needed to strengthen family and informal caring arrangements

- make connections to mainstream services and community supports

- provide information about relevant government and community services in the area

Eligibility criteria include being aged under 65 and having a significant permanent disability which requires assistance or support (disabilities may be attributed to intellectual, cognitive, neurological, sensory, or physical impairments, or a psychiatric condition). There may also be other age and residence requirements, which depend on the trial site.

There is a strong impetus in the scheme to support improving social and economic participation for the person living with disability, and thus, with the individual nature of the support plans, could include vocational support and assistance. However, eligibility requirements for mental health consumers are unclear at this stage and a diagnosis of permanent impairment is required. This could work to exclude vulnerable young people who may require assistance in the key few first years of their illness while their diagnosis/treatment is being identified. Also problematic is that young people who could benefit from early intervention assistance may not classify themselves as having a disability and thus may not be aware of this potential source of support.

11. INTERNATIONAL INITIATIVES

11.1. EARLY INTERVENTION

Key Stage 4 Engagement Program (KS4EP), UK

The KS4EP is an individualised program for 14 to 16 year old students at risk of disengagement from school. This program was integrated into the school curriculum. Key program components include:

- The development of soft skills (personal, social, and functional)
- Vocational options such as hair and beauty, sport and leadership, and pet and animal care
- Support from a trusted adult
- Holistic approach to program delivery

A national evaluation found that:

- 77% of Year 11 students enrolled in the program progressed to further study, and 6% progressed to employment;
- School attendance improved;
- Improvements in self esteem, confidence, interpersonal, and practical skills were observed. (5)

Manukau Institute Secondary Tertiary High School, NZ

New Zealand's tertiary high school was designed to thwart the abrupt transitions typical of many education systems throughout the world. Though completion of the senior years of secondary school predict the best employment outcomes in Australia, it can be argued that encouraging completion of Years 11 and 12 for their own sake does little to assist those struggling to remain engaged. Hence, New Zealand's Tertiary High school takes such students and offers a planned transition and identification of vocational pathways. Students enter the program in Year 11 and simultaneously complete their secondary qualification as well as a two year Career and Technical Education qualification. The high school curriculum is well integrated with the post-secondary qualifications, and students retain their link with their previous school. Thus, students can be engaged in the attainment of multiple qualifications, and attached to multiple institutions simultaneously, which increases the social scaffolding around these at-risk young people (Centre for Studies in Multiple Pathways, 2011).

The 2011 Annual Report demonstrated promising findings considering the at-risk status of enrolled students:

- 81% of students completed the course
- 61% completed a qualification during the year
- 44% of those at levels 1-4 progressed to higher level study (10 levels total)
- 61% of students were retained in study at the same institution

In addition, though the program is highly vocational, some students are reported to have re-engaged with learning and chosen an academic pathway, which the tertiary high school flexibly caters for. The success of this tertiary high school program supports a finding that 70% of early school leavers feel confident that they could graduate high school if they wanted to (Middleton, 2011). This highlights the importance of finding alternatives to the mainstream education, which offers a one size fits all approach.

Skillforce, UK

The SkillForce program is a school-based complement to mainstream education that delivers activity based learning outside the classroom. The program is aimed at 14 to 16 year olds who are at risk of disengagement, and it has assisted some 35,000 young people since its inception around ten years ago. A unique aspect of this program is that instructors are participants of the Military to Mentor program; that is, instructors are former military personnel. Class sizes are small (15-20 young people) and students are encouraged to earn awards and qualifications, with an additional aim of improving attendance. A four day workshop is offered in students' first year of study to build teamwork skills, confidence, and character.

Program outcomes include:

- 60% of students with free school meals entitlement continue in further education, compared with 6% nationally.

- Exclusions are 7%, an improvement from the predicted 30%.

- Skillforce has created an estimated cost saving of £40 million per year through NEET intervention.

Extended schools and school-based programs

The 'Youth Matters' policy in the United Kingdom encourages a place-based approach to service provision. Local needs are responded to by integrating services and using the school as a hub. Schools are extended to deliver not just education, but community access to school resources, childcare, recreation, sport, and referral to specialist services.

Aiming High, a strategy introduced in 2007, aims to provide young people with positive recreational activities and youth services in local areas. The strategy guarantees access to learning, sports, cultural and community opportunities to all young people, but especially disadvantaged young people. This holistic approach was based on research demonstrating that:

- social and behavioural skills are more modifiable than cognitive skills (Choudhury et al., 2006); and

- improvement in social skills was linked with greater educational, employment, and mental health outcomes in later life for young people from low socioeconomic backgrounds (Carneiro et al., 2007)

A program evaluation found that:

- Young people enjoyed participating in the provided leisure and educational activities

- Young people gained new skills and interests and experienced improvements in self esteem and social skills

- Important program elements identified included one to one interaction, peer to peer approaches, allowing young people to bring a friend, encouraging leadership and ownership, parental involvement, and communication between schools and other key professionals.

While Australia lacks policies that require integrated services and youth centres in all areas, there is some evidence that such initiatives are emerging. For instance, an extended school hub pilot has been initiated in Victoria as part of the National Partnership for Low Socio-economic Status School Communities (Bond, 2010).

Dual Systems Approach

While Australia's education system is 'unitary', with all students following the same academic pathway, Europe and Scandinavia have a dual systems approach in which multiple pathways are available to students who have particular aspirations (Centre for Studies in Multiple Pathways, 2011). Through this approach, students are engaged in class-based learning and

work-based learning simultaneously. A disadvantage to this system is that it does require a choice in occupation before commencement of upper secondary education, with changes in occupation after training costly. A limitation to this approach is that it is difficult for many teens to know what path they aspire to at such a young age. However, the NEET rate is very low in countries with a dual system (Gracey & Kelly, 2010), highlighting the importance of supporting young people into work environments early.

11.2. SUPPORTING EDUCATION

Back on Track

Back on Track is an education course developed for the vocational support of young people with first episode psychosis in Portsmouth, UK. This program was designed and implemented by a partnership between Headspace, a NHS Early Intervention in Psychosis Service, and a further education college. The course aims to increase community participation and attainment of qualifications, and fosters social, goal-setting, recovery and self-management skills. The course provides an opportunity for students to see themselves not as merely a 'patient' but as a student and a member of the community.

A unique aspect of this program was the inclusion of cognitive assessments designed to identify students' specific cognitive impairments that might interfere with educational and vocational functioning. Headspace (UK) service users often reported difficulties with memory and organization. Importantly, Ringland (2011) pointed out that many young people either lack awareness about the causes of their difficulties, or are less able to articulate them. Nonetheless, surveys of people with disabilities indicate that many suffering from mental health disability consider the impact of their disorder to be their main obstacle to social participation (e.g., Lawler & Perkins, 2009; NZ Office for Disability Issues, 2009). Thus, there seems to be a need for increased knowledge about the specific impact of mental health on functioning. For instance, there is some evidence that cognitive impairments may manifest in the prodromal phase of schizophrenia before symptoms emerge (Niendam et al., 2009). Cognitive deficits may include impaired memory and executive function, and difficulty sustaining attention or processing information (Ringland, 2011). Cognitive remediation therapy has been found to improve working memory (Wykes et al., 2007) which may be beneficial for overall cognitive performance and functional outcomes in people with schizophrenia (McGurk et al., 2007; McGurk et al., 2009). Based on such studies, developers of the Back on Track program reasoned that young people with cognitive impairments who wish to return to work or study may thus need tailored assistance to overcome or compensate for their specific cognitive difficulties.

The Back on Track program used results from cognitive assessments to devise compensatory strategies. For example, a disagreement between verbal and visual memory was frequently observed, so program facilitators made sure that information was presented both visually and verbally. The cognitive assessments were also used in some cases to aid career goals. One particular student struggled with systematic planning, but creative problem solving was a strength. This student was therefore encouraged to avoid future vocational choices that were comprised of a high amount of technical content.

Participants in the Back on Track program demonstrated increased wellbeing, and social confidence. Clinical records indicated a reduction in mental health service use during the program. Around 50% of the learners exited Back on Track into conventional education, paid employment, or voluntary work. Engagement was more difficult for those participants with more complex needs such as comorbid autism spectrum disorders, which are overrepresented in the first episode psychosis population. Autism spectrum disorders can present additional difficulties with processing social and sensory information.

11.3. SUPPORTING TRANSITIONS

Career Academies

Career Academies are one of the few evidence-based transition programs available. Career Academies offer full-time education for young people in Years 9-10 through to Year 12. The curriculum includes both academic and technical content, based around a specific career theme. Importantly, career options are wide, and not limited to entry level occupations. Students learn in the classroom, and participate in on-the-job training.

Allocation to the program was randomised, permitting inferences about causality. The Career Academies program was evaluated with both short term and long term follow up. Key findings include:

- The program had no short term impact on educational outcomes such as test scores and graduating on time.

- However, the program led to a significant improvement in employment, hours worked, and wages at 4 and 8 year follow up for young men.

- Thus, even if a transition program does not appear beneficial initially, it may have long-term effects.

- Students with greater support from teachers had lower dropout rates. Students with little to no interpersonal support had higher dropout rates and lower school engagement.

- The program had no significant impact for young women. (Kemple and Willner, 2008)

Steps to Success

The Steps-to-Success program was designed to aid school-to-work transitions for students in Years 9-12 who were at risk of disengagement as a consequence of emotional or behavioural disturbances. The program was delivered in a vocational and technical school in the United States. The central elements of the program were:

- Person-centred education and careers planning

- Vocational-oriented curriculum and employability skills training

- Progressive inclusion of participants into vocational courses based on individual interests

- Paid and unpaid work placements

- Support services at school and work experience, e.g. tutoring, mentoring

- Clinical treatment including individual, family and/or group therapy

Post-secondary outcomes for young people enrolled in Steps-to-Success were compared to outcomes for two groups of young people in the same geographic location: (i) young people with no emotional and behavioural disturbances, and (ii) young people with emotional and behavioural disturbances who were not receiving transition support.

The healthy controls fared better than Steps-to-Success participants in terms of employment, post-secondary education, and incarceration outcomes. However, the results indicated that transition support for young people with mental health issues led to an improvement in post-secondary outcomes, compared to those with mental ill health who did not receive transition support. However, transition support provided no added benefit for the future employment outcomes of young people with mental ill health, perhaps because of the substantially increased likelihood of post-secondary education for program participants. Overall, around 70% of Steps-to-Success participants transitioned to post-secondary education or employment, compared to around 60% of young people with mental health problems who did not receive transition support (Karpur et al., 2005).

Street League UK

Street League incorporates sports and employability skills into three different programs for 16 to 25 year olds.

Street Football is an 'entry level' engagement program that focuses on confidence building and soft skills. This program consists of weekly 2 hour football sessions. Participants are then moved on to more intensive programs as they are ready.

The Academy program aims to improve employability and teamwork via football and fitness, the achievement of qualifications, and work experience. The duration of the program is 8-12 weeks.

The third program is an aftercare program named The Graduate League. Graduates from Street Football and the Academy are asked to participate in monthly football and fitness events. Staff members follow up on graduates to ensure that they are sustaining their engagement in employment or education.

Program outcomes included:

- 864 participants between April 2012 and March 2013, with 82% progressing on to education (n = 211), employment (n = 391), or training (n = 101);

- 74% of these sustained their engagement for three months, and 49% sustained engagement for six months;

- 90% of graduates report feeling that they had better links to the local community through their participation in Street League;

- 86% experienced health improvements.

11.4. SUPPORTING WORK

Youthbuild UK

Youthbuild is a supported employment program for young NEET people with multiple barriers including criminal records, and alcohol and substance abuse. Although the key aim of the program is to place participants into employment, Youthbuild also incorporated the following elements:

- A strengths based approach in order to support young people to overcome barriers;

- individualised service provision;

- communication with other services and partners; and

- a financial incentive to enhance motivation and remove financial barriers.

In an evaluation of the second year of the program,

- 93% of participants completed the six weeks training;

- 74% of participants completed six months' subsidised employment (increased from 63% in the first year of the program);

- 70% of participants who completed the Youthbuild program secured full-time employment, and 63% sustained employment for at least three months. Again, an increase was observed compared to the previous year (~50%); and

- The holistic approach of the program had a positive effect on many aspects of young peoples' wellbeing, including increased confidence and aspirations, improved interpersonal and family relationships, and improved attitudes towards education and support for mental health.

Year Up

Year Up is a program designed for at-risk young adults from low socioeconomic backgrounds. The program runs for 12 months, with the first six months comprised of hands-on learning and

the development of soft and hard skills. In the second half of the program, students are placed into a corporate internship. The students sign contracts surrounding expectations and behaviour. The students also get paid a stipend, and are penalised fifteen dollars per week for breaches of the contract.

The program appears to be very successful, with 84% of participants gaining employment or moving on to post-secondary education within 4 months of program completion. Those who gain employment earn on average $15 USD per hour, or $30,000 USD per year. The Economic Mobility Corporation referred to these program outcomes as "the most exciting evaluation results we've seen in youth employment in 20 or 30 years, and the first to show a really substantial earnings gain." (Roder, 2011)

12. AUSTRALIAN INITIATIVES

12.1. EARLY INTERVENTION

The Bridge Program

The Bridge Program, run by Edmund Rice Education Australia YouthPlus*, provides alternative education for severely disengaged 12-15 year olds in Queensland who have a history in youth justice or child protection (Walsh & Tilbury, 2011). The program runs for 20 weeks, and clients are subsequently offered transition support in order to engage with an institution. Important aspects of the program were small group size, individualised attention and support, and learning activities that are relevant to the real world.

More than half of the enrolled young people had substance misuse disorders, and 20% had a diagnosed disability including conduct disorder. The evaluation did not explicitly mention responses to mental illness, although young people were referred to health and welfare services as needed.

An independent evaluation of the program was conducted, which found that 62% of those enrolled moved on to engage in education or training. Of these, 79% were in alternative education, 16% were attending mainstream schools and 6% were in employment or traineeships. Evaluators noted that it was not clear which program elements (if any) were informed by a research base. One recommendation that emerged was the importance of hiring a social worker or psychologist.

12.2. SUPPORTING EDUCATION

Brotherhood of St Laurence Community VCAL Program

In 2010, the Brotherhood of St Laurence ran a small Community VCAL program for young people aged 15-18 years who experienced barriers to education including expulsion or early school leaving (Myconos, 2011). This program delivered the Victorian Certificate of Applied Learning in a community setting instead of in a school, which was found to be beneficial for disengaged students, particularly due to the adult learning principles. The VCAL delivers classroom lessons alongside vocational training and work placements. Throughout the year, teachers engaged in professional development to learn skills such as how to deal with challenging behaviours, and mental health first aid. The following transition support was provided: (a) a weekly study group for students who entered further training, (b) all ex-students were regularly contacted to assess support needs, (c) a Facebook page provided a forum for past and present students to share transition experiences.

In this program, 12 of 14 students at Year 11 level progressed to Year 12, and 10 of 11 students at the Year 12 level graduated. There were also improvements in students' attendance (79%) and confidence. Small class sizes allowed mixed-ability classes with an individualised approach for each student. An emphasis on adult learning principles was valued highly by students and perceived as instrumental in creating a positive learning environment and improvement in student demeanour. Taking an adult learning approach, students are treated as young adults capable of making decisions about their own learning. For instance, students were permitted to leave the classroom as they pleased, smoke on the premises, and have facial piercings.

Some key issues emerged from the program evaluation. It was reported that teachers who delivered this program needed to demonstrate commitment, passion, creativity, flexibility, and empathy. In short, it was noted that teaching in this setting required skills that were not taught as part of a conventional teaching degree. Although the staff were held in high esteem by students and parents, teachers found it difficult to cope with students' complex needs. Teachers stated that they did not realise how much social work would be required in the classroom, and that they felt they were doing students a disservice by not having wellbeing specialists. It was

reported that the program would benefit from access to more information about the students' existing needs and reasons for disengagement. Additionally, while students were quite confident with regards to numeracy, literacy skills remained low. Thus, the evaluation highlighted the necessity of support staff specialising in wellbeing or literacy. Students expressed a preference for an additional staff member who could provide welfare advice. According to Myconos (2011), this preference indicated students' need for emotional support.

Peninsula Youth Connections

Peninsula Youth Connections (PYC) is a government funded intervention for young people in Frankston and Mornington Peninsula who have disengaged from school or who are at risk of disengaging. An intensive case management approach was used to support the overall aim of Year 12 completion and successful transition onwards. Progressive and final program outcomes were selected for each individual. The aim of the progressive target outcomes was to address and minimise various barriers to engagement; for instance, disability, literacy and numeracy, or low self esteem. Young people were also selected for specific final outcomes, such as engagement in employment or improved academic performance.

Key findings:

- 84.5% of young people achieved at least one outcome. 78.8% were working or studying on three month follow-up, indicating sustainment of intervention gains despite ongoing mental health problems. Additionally, after the program young people were in more regular contact with school, friends, and activities out of the home.

- A strength of the PYC was collaboration with other service providers in the region, Headspace in particular. Interestingly, while case managers felt ineffective in responding personally to mental health needs, the young people reported satisfaction.

- The program was most effective for young people with mental health concerns, interpersonal issues and learning issues. The program was less effective for young people with family instability and risky behaviours.

- Suspected or diagnosed mental health issues were a barrier to engagement for 41.7% of participants. Other common barriers included low self esteem (71.5%), low literacy or numeracy (61.8%), financial problems (51.3%), social problems (49.6%), inadequate family support (42.1%), behavioural problems (39%), bullying (28.5%), anger management (26.8%) and substance misuse (17.1%).

- Young people valued the following aspects of the PYC program: friendliness, lack of formality, personal support, encouragement, flexibility, persistence and enjoyment. Individualised case management was considered essential by these young clients. Service provision was flexible, with meetings often held in homes or public places, and text messaging a common form of communication.

- Enrolment durations were variable and based on individual needs. Young people were permitted to enrol as many times as they liked. Young people with mental health issues had the shortest enrolment durations, with most exits occurring due to achievement of outcomes.

- Disengagement from school has a profound negative impact on young people's confidence and self-esteem that could not be completely restored by this program, or as the authors argue, any other program. In this way, an experience of disengagement becomes a barrier to engagement in future.

- Exits from the program were not significantly greater for the more severely disengaged, indicating that PYC is able to engage young people at various stages of risk.

- For 78 participants, minimisation of mental health barriers was a program goal. Of these, more than 50% achieved this outcome. Moreover, those facing mental health issues also achieved a higher mean number of progressive and final program outcomes, compared to those struggling with learning difficulty, unstable environments or risky behaviour. Females achieved more outcomes than males. (Barrett, 2012)

This program aimed to support disengaged young people with a range of complex issues commonly associated with NEET and disengagement. The findings indicated that young people with mental health barriers were the most likely to benefit from this program, and also required the shortest enrolment duration to achieve positive outcomes. The implication here is that re-engagement is relatively straightforward for young people whose key barrier to work or study is mental illness.

12.3. SUPPORTING TRANSITIONS

SCISCO Career Pathways

SCISCO Career Pathways is a Queensland organisation that delivered three alternative learning programs for 90 disengaged 15-17 year olds in 2011 (Knight, 2012). The programs are 14 weeks in duration and take a holistic approach to re-engagement, incorporating a wide range of activities and support including:

- Attainment of qualifications such as Responsible Service of Alcohol, Senior First Aid, Certificate II in Workplace Practices, and Construction White Card.

- Work experience

- RESPECT Muay Thai Program which teaches discipline, respect, resilience, coping skills, decision making, and goal setting.

The daily curriculum is flexible and a sense of awareness is fostered among students regarding the wellbeing needs of other program participants. Wellbeing needs may include extra time to learn a difficult task, or the allowance of a 'mental health day'. Facilitators give lots of individualised attention to participants and provide support for emotional and psychological problems, as well as refer participants on to external mental health services when required.

Facilitators aimed to engage participants on three levels: cognitive, emotional, and behavioural. On the cognitive level, facilitators aimed to foster more positive cognitions and self-beliefs about their abilities. Many disengaged young people report unhelpful cognitions; for instance, that they are stupid, or a slow learner. Facilitators employ cognitive-behavioural strategies within the classroom, along with a range of other activities designed to improve key ingredients of mental wellbeing such as coping skills, problem solving skills, and the development of a rational and optimistic thinking style (Merry et al., 2004).

Emotional engagement was targeted through the provision of an individualised approach to curriculum delivery, which allows participants to relate the learning tasks to their personal goals. In addition, facilitators regularly encourage participants to discuss their feelings and frustrations to the group, in order to foster connectedness, empathy, awareness, and respect.

Behavioural engagement was less of a focus, and was approached principally through the minimization of barriers to participation (e.g., stress and anxiety, caring duties, housing issues, lack of transport money). Other strategies were used (e.g. token reward systems) however more attention was paid to emotional and cognitive engagement. The program evaluators suggested that the positive behavioural outcomes observed (e.g. participation) may suggest that the strong emphasis on emotional and cognitive engagement also facilitated behavioural engagement.

Participants' engagement was measured using a customised assessment tool, adapted from The Engagement Matrix designed by the South Australian Department of Education Children's Services. The tool was modified to encompass six facets of engagement important for success in education and employment: (i) engagement with *learning* tasks, (ii) *wellbeing* and management of emotions and behaviours, (iii) class *participation,* (iv) *relationships with adults*, (v) *peer interaction*, and (vi) engagement in *work experience and skill development*. Facilitators assign a score to for each category of engagement, and these scores are summed to yield an overall engagement score. Fifty six students were measured over four time points. Most participants (93%) increased their engagement over time.

Results indicated that 91% of participants completed the program, and 87% transition to further EET. Literacy and numeracy improved even though the program did not focus on these skills.

The program also improved mental wellbeing, self-esteem, and self-efficacy, as measured by validated scales pre- and post-intervention.

Boystown pre-employment and transitional employment programs

Boystown is a charitable youth organisation that focuses on improving the quality of life for young people at risk of social exclusion. Boystown activities include Kids Helpline, parenting programs, and family refuges, as well as the following training and employment services:

- Job Services Australia, which targets young people in disadvantaged areas of Australia.

- Training, Education and Support Services consisting of pre-employment training for young people disengaged from school.

- Transitional Employment, which offers paid work placements to disengaged young people via social enterprises, alongside individualised case management and counselling. One such program in Queensland supports young people to acquire vocational skills such as landscaping, car washing, graffiti removal, construction, and furniture assembly.

Based on research conducted by a linkage between Boystown and Griffith University, the following strategies for responding to mental health issues in young disengaged people were identified as critical:

- Provision of opportunities to improve wellbeing and self-esteem

- Relevant work skills training

- Mentoring and support relationships

- Case management for the enhancement of personal development

Importantly, in a submission to the House Standing Committee on Education and Employment, Boystown argued that responses to mental health issues in young people can be improved by increasing the availability of specialist mental health assessments within the Australia Job Services Network.

"It is the experience of BoysTown's employment consultants that many young people have undiagnosed mental health issues. Many young people either do not want to seek assistance or fear that disclosure of their mental health problem may lead to stigmatisation and subsequently be a further impediment to securing employment. Consequently the initial assessment of young people prior to referral to a JSA provider may not identify that there is an underlying mental health issue. Furthermore the availability of assessment services are becoming more limited. DEEWR recently advised all service providers that Centrelink's Participation Solutions Team (PST) would start restricting the amount of enquiries that it would respond to from Job Services Providers. Without opportunity for reassessment by a Job Capacity Assessor the Job Service provider is limited in the level of support that can be made available to young people with mental health issues to prepare them for employment." (Boystown, 2011)

In general, Boystown initiatives are successful:

- More than three-quarters (77.4%) of participants remained engaged with BoysTown and completed their program.

- Transitions were successful, with 61.3% entering into full-time employment, education or further training. An additional 11.9% obtained part-time or casual employment.

- Of those who commenced full-time participation, 89% sustained their engagement after 13 weeks, while 80.3% sustained their engagement for at least 26 weeks.

- *"The overall 73.2% positive employment and education outcome rate for participants in BoysTown's employment programs appears to be higher than the benchmarks for similar target groups in the national Job Services Australia labour market assistance programs."* (Barlett et al., 2012)

- Pre and post measures of the General Health Questionnaire and Rosenberg Self Esteem Scale indicated that young people participating in Boystown's social enterprises

experienced improvements in feelings of uselessness, self respect, ability to face up to problems, and self pride.

- Improvements in literacy, numeracy, communication, decision making, optimism, and goal setting were observed.

- Decreases in substance use, criminality and antisocial behaviour were observed. (Boystown, 2011)

Northern Sydney Local Health District VETE Service

The VETE (Vocational Education and Training and Employment) Service at Northern Sydney Local Health District (formerly Northern Sydney Central Coast Area Health Service) has been providing vocational education, training and employment service to people with severe mental illness in the NSCCAHS areas since February 2007. The NSCCAHS VETE Service has been recognised as good practice having won 6 awards in Australia, including:

- 2012 Institute of Public Administration Australia (IPAA) Individual Excellence Award
- 2010 NSW Premier's Award
- 2010 NSW Premier's Award Commendation for Individual Excellence
- 2009 NSW Health Awards
- 2009 NSW Mental Health Association, Mental Health Matters Award
- 2009 The Mental Health Service Conference Gold Award

NSCCAHS VETE Service was also a Finalist in the 2011 Prime Minister's Award.

The VETE Service adopts a dual approach of using partnerships and in-house vocational rehabilitation specialists to improve the vocational pathways and service flexibility for people with disability. VETE Consultants are Rehabilitation Consultants who have worked extensively in disability employment settings. Their role is to assist mental health consumers to access the appropriate levels of support for their education and/or employment goals.

VETE Interventions are tailored for individual consumer needs and may include:

- Vocational assessment

- Vocational counselling

- Benefits counselling

- Assisting with the Federal Government assessment process

- Liaising with internal and external service providers

- Support with enrolment at vocational training courses

- Referral to Disability Employment Service providers, TAFE, NGOs

- Providing resources to clinicians and consumers regarding vocational/career/training information

- Assisting with Department of Human Services (Centrelink) processes/issues with service providers as they relate to employment

- Assist with employment opportunities at Australian Disability Enterprises (ADE)

VETE Consultants do not provide ongoing job seeking support to consumers, but instead help connect consumers to relevant employment services.

12.4. SUPPORTING WORK

Mates in Construction

The MATES in Construction organisation was established by BERT (Building Employers Redundancy Trust) in response to the high suicide rate for Queensland construction industry young workers (reportedly twice the national average for men).

The MATES in Construction model comprises a training program targeted at building employees on construction sites at three levels:

- General Awareness Training (GAT) – suicide facts; practical guidance on how they could assist

- Connector Training - recognition of symptoms/ signals; provided to volunteers

- ASIST Training – face to face intervention/ support for those contemplating suicide

A recent evaluation found that the "feedback received with regards to the MATES in Construction program amongst workers on accredited sites is overwhelmingly favourable."

The evaluation found:

- There was strong awareness of MATES, with 91% of workers across 11 sites aware of the program.

- The purpose of the program was clearly understood

- The program appeared to be valued on site by those who have undergone training and were more involved. However, the researchers note that a third of those on site were not sure about the value, which the researchers explained as due to a lack of direct experience with the program.

- The impact on site was resported as an increase of awareness of the issue; encouraging workers to look after mates; help is available; there was no need to be ashamed.

- The help received is highly rated.

The ASIST workers report that workers do not seek help directly themselves but are referred by someone they work with, which the researchers note highlights that Connectors are an essential part of the program.

13. BIBLIOGRAPHY

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