



**Centre of Full Employment and Equity**

**Working Paper No. 08-13**

**Disability Employment Reform, Social Inclusion and Mental Health**

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December 2008

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## 1. Introduction

There has been an increased focus on how to design employment policy for people with mental illness in recent years. Mental illness is among the top causes of disability in Australia (ABS, 1998) and accounts for 13 per cent of the disease burden in Australia in 2003 (AIHW, 2006). According to the data collected in the National Survey of Mental Health and Wellbeing in 1997, approximately one in five Australian adults will experience mental illness once in their lifetime, with the highest prevalence being among young people 18 to 24 years of age (ABS, 1998). The latest Survey, conducted in 2007, shows a dramatic increase in the prevalence of mental disorders among Australians. Forty five per cent of Australians aged 16-85 years have experienced a mental disorder at some point in their life, and 20 per cent had a mental disorder 12 months prior the interview.

Employment has been recognised as one of the essential aspects of a successful recovery programme for those with mental illness (Leff and Warner, 2006) and paid work has been highly valued by those who experience mental illness (SANE, 2006). 'Employment ... has the potential to reduce symptoms, enhance self-esteem, reduce disability, improve independence and provide an overall better quality of life' of people with severe mental illness (Frost, Carr and Halpin, 2002: 3). Unfortunately, despite the benefits they may experience from employment and their desire for paid work, people with severe mental illness are among the most disadvantaged in the labour market. Bill *et al* (2004: 10) state that unemployment 'acts as a form of social exclusion and violates basic concepts of membership and citizenship'. This sense of social exclusion is magnified for those with mental illness.

Leff and Warner (2006: 106) also discuss the importance of employment in assisting a person's recovery from mental illness. Their study examines the full employment European countries immediately after the Second World War (for example, Britain, Norway, Switzerland and the Netherlands). During the periods of full employment the rate of complete recovery from schizophrenia was more than 30 per cent and social recovery was more than 50 per cent. However, during the last 20 years of the twentieth century these countries experienced higher unemployment rates and significantly lower recovery rates in schizophrenia. Full recovery was less than 20 per cent and social recovery 30 per cent.

The aim of the Australian government's recently announced social inclusion agenda is to develop a governance structure in order to combat economic and social disadvantage in Australia. This requires rethinking existing policy and related programs in order to provide an inclusive society for all Australians. Priority areas for social inclusion, identified by the Government are: jobless families with children, children at risk of long term disadvantage, employment for disabled people including the mentally ill, the homelessness, particular local communities and neighbourhoods, and Indigenous Australians (Australian Government, 2008b). Current arrangements of the Disability Employment Services (DES) are being reviewed and the outcomes will be notified in the National Mental Health and Disability Strategy.

The paper analyses the labour market situation of people with mental illness from the latest Survey on Mental Health and Wellbeing and compares it with the results from the previous survey. It looks at the progress in the review of the DES and the meaning of social exclusion and social inclusion for people with mental illness.

The paper is organised as follows: Section 2 provides a descriptive analysis of the labour market status of persons with mental illness. Section 3 presents a brief description of the current disability employment policy and summarises the DES review which is currently underway. The next section develops the concept of social inclusion and exclusion and relates it to the situation faced by persons with mental illness. The fifth section outlines an alternative macroeconomic policy approach designed to increase social inclusion for those with mental disabilities. Section 6 concludes.

## **2. The labour market situation of persons with mental illness**

Table 1 represents the prevalence of mental disorders by labour force status derived from data collected in the two successive National Surveys of Mental Health and Wellbeing of Adults, conducted in 1997 (ABS, 1998) and 2007 (ABS, 2008). In both years the highest prevalence of mental disorders was among the unemployed. In 1997, 26.7 per cent of unemployed adults had experienced a mental disorder during the twelve months prior to the survey. In 2007, the number of the unemployed experiencing a mental disorder within the last 12 months was 29.4 per cent. Of interest, is the fact that between 1997 and 2007, the prevalence of mental disorders significantly increased among the employed, with the highest rate among adults employed part-time (22.1 per cent in 2007, compared to 17.9 per cent in 1997). Over the same period, the prevalence of mental disorders during the twelve months prior to the interview increased by nearly 30 per cent among the full-time employed and nearly 25 per cent among those who were part-time employed. Anxiety disorders (involving feelings of tension, distress or nervousness) are particularly on the rise for both the employed and unemployed. In 2007, the unemployed experienced the highest rate of any type of mental disorder, with the highest prevalence of anxiety disorders (17.5 per cent). Compared to 1997, the prevalence of substance use disorders decreased among employed, unemployed and those not in the labour force. However, the highest rate of substance use disorders was still among the unemployed (11.1 per cent), nearly double the rate of the employed people. Anxiety disorders were the most prevalent type of disorders among people not in the labour force in both 1997 and 2007 (14.5 per cent).

The unemployment rate of persons who experienced any mental disorder during the 12 months prior to the interview decreased from 10.1 per cent in 1997 to 5.4 per cent in 2007 (See Table 2). There was an increase in part-time employment of persons with any 12-month mental disorder from 28.9 per cent to 34.8 per cent, while full-time employment declined. Since 1997, the labour force participation rate has increased for persons reporting each type of mental disorders. However, over the ten year period (1997-2007) people with affective disorders (involving mood disturbance) occupied the worst position in the labour market compared to other mental disorders, with the lowest labour force participation rate (66.4 per cent) and the highest unemployment rate (9.8 per cent) in 2007.

Table 1 Prevalence of Different Mental Disorders by Labour Force Status, per cent, 1997 (\*\*) and 2007

Type of disorder	F/T		P/T		UN		NILF	
	1997	2007	1997	2007	1997	2007	1997	2007
Anxiety	7.1	13.4	10.2	15.7	14.9	17.5	14.5	14.5
Affective disorders	3.8	5.5	6.4	6.1	10.1	15.9	8.9	6.5
Substance use disorders	7.8	6.0	7.2	5.8	15.6	11.1	6.4	2.9
Total mental disorders (*)	15.0	...	17.9	...	26.7	...	22.0	...
Any 12-month mental disorder (a) (b)	...	19.3	...	22.1	...	29.4	...	18.6
Total persons ('000)	6,104.1	6921.5	2,420.2	3526.3	565.4	413.6	4,375.1	5154.0

Source: ABS (1998), ABS (2008),

Notes: (a) Persons who met criteria for diagnosis of a lifetime mental disorder and had symptoms in the 12 months prior to interview, (b) A person may have had more than one 12 - month mental disorder, (\*) During the twelve months prior to interview (\*\*) Age standardised rate.

Table 2 Rates of employment, unemployment and labour force participation for people with mental disorders (per cent), 1997(\*\*) and 2007

Type of disorder	F/T		P/T		UN		LFPR	
	1997	2007	1997	2007	1997	2007	1997	2007
Anxiety	56.7	59.7	32.3	35.6	11.0	4.7	54.7	67.5
Affective disorders	52.2	57.6	34.9	32.6	12.9	9.8	53.3	66.4
Substance use disorders	64.5	62.4	23.6	30.7	11.9	6.9	72.5	81.7
Total mental disorders (*)	61.0	...	28.9	...	10.1	...	60.9	...
Any 12-month mental disorder (a) (b)	...	59.7	...	34.8	...	5.4	...	70.0

Source: ABS (1998, Table 8), ABS (2008, Table 5), Bill et al 2004, Table 1 and Author's calculations

Notes: Notes: (a) Persons who met criteria for diagnosis of a lifetime mental disorder and had symptoms in the 12 months prior to interview, (b) A person may have had more than one 12 - month mental disorder, (\*) During the twelve months prior to interview (\*\*) Age standardised rate.

Table 3 shows weekly wage distribution over 2004, 2005 and 2006 for persons with a psychiatric disability working in open and/or supported employment. There has been significant change in the distribution over the three Censuses. The proportion of people with a psychiatric disability who earn less than \$100 decreased over the three year period from 33.8 per cent in 2004 to 25.4 per cent in 2006. Over the same period the proportion of people earning more than \$300 also declined 2.4 percent to reach 30 per cent in 2006. However, since 2004 there has been a dramatic increase of more than 10 per cent in the proportion of people earning between \$100 and \$300.

Table 3 Weekly wage distribution for persons with psychiatric disability in open and/or supported employment, per cent

Weekly wage range	2004(*)	2005	2006
No wage	...	3.0	0.2
\$0-\$100	33.8	32.3	25.4
\$101-\$300	33.8	34.0	44.5
\$300+	32.4	30.7	30.0

Source: FaCS (2005), FaCSIA(2006), FaCSIA (2008)

Note: (\*) Weekly wage distribution range is \$0-\$100, \$100-\$300 and \$300+ (FaCS, 2005)

From the above descriptive analysis it is clear that the labour market situation of people with mental illness has notably changed during the last decade. However, despite the decrease in the unemployment rate and an increase in labour force participation, the level of employment is still far from the desirable. We argue that only full employment, that is, paid work for any person able and willing to work, is recognised as the desirable level of employment. Persons with particular types of mental illness, such as affective disorders, still experience high levels of unemployment; nearly 10 per cent. In terms of the weekly wage distribution, persons with mental illness have not fared well since the proportion of persons earning higher wages is decreasing, and the proportion earning lower wages is increasing.

The following sections discuss the importance of employment for mental health and overall wellbeing and the reasons why it is necessary for the government to maintain full employment.

### 3. Current arrangements in employing people with disabilities

We argue in this paper that the maintenance of full employment for all Australians, including those with disabilities is the responsibility of the Federal Government. As we show in this section, the current policy framework falls a long way short of this preferred state.

There are two categories of labour market policies financed by the Government: active and passive. Active labour market policies are generally grouped into four categories: First, job search assistance. Second, job creation schemes which are usually temporary programmes in a public sector with the purpose to create jobs for the unemployed. Third, wage subsidies paid to employers when they hire jobseekers from disadvantaged groups such as: people with disabilities, long term unemployed, sole parents, young people and ethnic minorities. Finally, formal training programs with the purpose of supporting job seekers to develop skills and enhance their productivity. Unemployment benefits paid to the unemployed as a form of social assistance are passive labour market policies (Cook, 2008).

In Australia, provision of employment services to people with disabilities, including persons with mental illness, is organised through three *mainstream services*: the Disability Employment Network (DEN), Vocational Rehabilitation Services (VRS) and the Job Network.

All three types of services have rapid job search in open employment as a recognised goal. However, there is a difference among these services particularly in consideration to the support provided to people with disabilities to retain employment. *Other*

services available to people with disabilities are: Business Services – assistance in employing and supporting people with disabilities in a sheltered working environment, Personal Support Program, Job Placement, Employment and Training Program, Work for the Dole, Job Placement Services, Work Experience Placement Program and Using Australian Job Search (Australian Government, 2008a; DEEWR, 2008).

### *Review of Disability Employment Services*

One of the commitments of the Federal Government is to develop a National Mental Health and Disability Employment Strategy that will “outline how policy and programs across portfolios and state, territory and Commonwealth governments can work together to help people with disability and mental illness gain and retain work” (DEEWR, 2008: 3). Thus, Disability Employment Services are currently being reviewed with the aim to make changes to the current arrangements and as a result improve the chances of people with disabilities for social inclusion. Particular attention in the review is given to the DEN and VRS. Therefore, existing DEN and VRS contracts have been extended to February 2010 until the review takes place.

The discussion paper accompanying the review of the Disability Employment Services (DEEWR, 2008) states that a number of submissions have been made to the National Mental Health and Disability Employment Strategy and the Employment Services Review. These submissions underline various strengths and weaknesses of the current system. Some features of the current system have been identified so far as a positive. First, it is an approach that supports early intervention for job seekers with disabilities. Second, vocational assessments of the disabled job seekers. Third, job placement and ongoing support on the job. Finally, job matching according to the skills and needs of a disabled person and assistance in order to increase the work capacity in case of illness or injury.

On the other hand, the submissions have identified some fundamental weaknesses in the current policy framework. First, in addition to finding and retaining a job, building a strong relationship with employers has been identified as a necessity. Second, the current arrangement of disability employment services has been recognised as too complex, particularly in the area of eligibility and assessment for certain programs. Originally eligibility criteria for DEN and VRS in the Disability Services Act in 1986 have been changed as a number of new components have been added over time. Hence, eligibility assessment of a disabled job seeker for certain programmes has become very complex and difficult. As a result of this, some job seekers fail to benefit from the services they actually need, and were excluded as they were assessed as ineligible. Third, particular concern was expressed about the issue that job seekers do not get the right nature or intensity of support. This arises from the complexity of the assessment used to determine the funding level for each job seeker. In particular, it is difficult to determine the level of support in DEN as there are eight different levels of funding. Finally, it has been recognised as important that people with a disability get placement in a job that will meet the individual needs of the job seeker, rather than any kind of job. Disability employment service providers need to concentrate on building up the skills of the disabled job seekers that will accord with the skills in demand in their local area.

In sum, minimising complexity is one of the top three areas that have been identified as crucial when looking at any changes to the current system, as well as improving flexibility and better access to vocational education and training. However, these are

only suggestions made by a various parties in their submissions to the Government. The outcome of the review will be notified in the National Mental Health and Disability Strategy.

#### **4. The social inclusion agenda**

We have to see the current review that is underway in the broader perspective offered by the Government's new, but as yet, ill-defined social inclusion agenda. In this Section we consider what a social inclusion agenda might involve and how it can be tailored to meet the needs of those with mental illness.

##### **4.1 Origins of the concept**

The term social inclusion is relatively new, particularly in Australia. An inevitable question that arises is: what does social inclusion mean? It is difficult to discuss social inclusion without mentioning social exclusion as these two concepts are strongly related. The concept of social exclusion was established before the concept of social inclusion. Contemporary use of the concept appeared for the first time in France, with the purpose of describing those who were not covered by the social insurance system such as the disabled, unemployed and sole parents. During the 1980s, it became prominent in Europe and since the 1990s it has been increasingly used in policy debates and discussions. The concept of social exclusion became particularly popular in the UK in 1997, after the election of the New Labour Government, when the Social Exclusion Unit (SEU) was created. In contrast to Europe, the concept has drawn insignificant attention in the United States (Hayes, Grey and Edwards, 2008; Peace, 2001). However, over the last few years there has been a noticeable shift in the focus of social policy from combating social exclusion towards the promotion of social inclusion (Spandler, 2007).

##### **4.2 What is social inclusion?**

A number of definitions of social exclusion and inclusion have emerged in the literature. Peace (2001: 29) states that while a great number of debates have attempted to provide a definitive conceptualisation of the term social exclusion, as yet, there is no consensus on the issue.

One influential definition (in policy terms) of social exclusion has been provided by the UK Social Exclusion Unit (Hayes, Grey and Edwards, 2008).

A shorthand label for what can happen when individuals or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown (Cited in Hayes, Grey and Edwards, 2008: 7).

In terms of social inclusion, the Australian Government provides the following description:

To be socially included, all Australians must be given the opportunity to: secure a job, access services, connect with family, friends, work, personal interests and local

community, deal with personal crisis and have their voices heard (Australian Government, 2008).

Clearly, these definitions are broad and do recognise various problems experienced by disadvantaged people. However policies and specific measures have failed to address these issues and produce a socially inclusive society. The proper definition of social inclusion will require an operational rendering that will clearly outline the most important factors of social exclusion and thus motivate explicit policy development. As we explained in section 2, the labour market situation of people with mental illness is still far from desirable. Both definitions do recognise unemployment as an obstacle to social inclusion. However, they do not outline the solution that will resolve the problems of persons with mental illness.

One of the definitions of the concept of social exclusion with a clearer focus, while still unsatisfactory, is provided by Huxley and Thornicroft (2003). They outline two concepts of social exclusion: the '*Demos*' and the '*Ethnos*' concept. The '*Demos*' concept refers to the number of rights accessible by the right of citizenship like: employment, education, housing, health, social security and community services. Lack of availability to access these services, particularly employment services, leads people with mental illness to social exclusion. Hence, measures targeted at social inclusion through '*Demos*' should provide better access to employment as well as to other above indicated services. The '*Ethnos*' concept refers to values that are shared by the members of particular social groups and cultural communities. Measures targeted at social inclusion through '*Ethnos*' should have an emphasis on psychiatric training to understand the relationship between mental illness and cultural values of certain social and community groups. The study concludes that the effectiveness of the *Ethnos*-related measures is dependant on the effectiveness of the *Demos*-related changes.

There is a clear focus on employment as the major factor of social exclusion of people with mental illness. The failure to provide access to employment and other services guaranteed as a right of citizenship, leads to ineffectiveness of other measures for social inclusion of people with mental illness within social and cultural groups.

In the following sub-section we discuss why policy development should emphasise employment.

#### 4.3 The importance of employment

Sayce (2001) discusses about complex relationship between social exclusion and mental illness. Some of the characteristics of social exclusion such as unemployment, low income or lack of social networks may be the result of mental illness. But the incidence of mental illness may also follow the loss of employment. It is difficult to disentangle the causal train and impossible using aggregated data. However, it is clear that employment is essential for social inclusion. Factors that lead to social exclusion are: 'lack of status, joblessness, lack of opportunities to establish family, small or non-existent social networks, compounding race or other discriminations, repeated rejection and consequent restriction of hope and expectation' (Sayce, 2001:122).

Leff and Warner in a study called *Social inclusion of people with mental illness* (2006: 101) state that employment is a 'fundamental measure of recovery' for people with serious mental illness as well as for their family members and clinicians. The ability to work and have a productive role provides a person with mental illness with



the opportunity for a meaningful social life. It improves their self esteem and normalises their relationship with family and friends. This approach is the core concept of the contemporary recovery movement. The unemployed person, with or without mental illness, has a higher risk of isolation, lack of interest, substance abuse and physical health problems. Also, the cost burden of the mental health treatment is lower for people who are working than for those who are unemployed. When general unemployment is high, it is more difficult for people with mental illness to obtain and keep a job. Most of them depend on some kind of social benefit, hardly sufficient for the essentials of life. They struggle to afford to pay for some basic types of social activities such as local sports events or cinema.

The unemployed could also experience a high level of psychological distress. Table 4 illustrates age standardised data on the prevalence of psychological distress by labour force status. According to the National Health Survey, Mental Health conducted in 2001 (ABS, 2003), 9.8 per cent of unemployed adults and 6.4 per cent of those not in the labour force experienced psychological distress as measured by the Kessler 10 Scale<sup>1</sup>. Among the employed people, 1.9 per cent of people were psychologically distressed and this is significantly lower than the average rate of 3.6 per cent. The same survey, by using the Socio-Economic Index for Area (SEIFA<sup>2</sup>), also finds that people who live in the most disadvantaged socio-economic areas have a greater chance for mental or behavioural problems than those from the least disadvantaged socio-economic areas, 12.3 and 8.1 per cent respectively. In the most socio-economically disadvantaged areas 7.5 per cent of females and 6.5 per cent of males experienced a very high level of psychological distress. In the least socio-economic disadvantaged, the percentage of people with psychological distress was significantly lower, 3.3 per cent for females and only 0.9 per cent for males.

Table: 4 Labour force status and level of psychological distress for persons aged 18 years and over, age standardised rate, per cent, 2001.

Labour force status	Males	Females	Persons
Employed	1.2	2.9	1.9
Unemployed	7.1	13.6	9.8
Not in labour force	7.1	6.0	6.4
Total	27	4.4	3.6

Source: ABS (2001: 11), Cat No. 4811.0

Mitchell and Muysken (2008) discuss employment as a basic human right which leads them to argue that the sovereign government should ensure there are enough jobs available at all times to guarantee that everyone has a job. They argue that, in the first place, employment is the major source of income which is necessary for participation in the market economy. But the contribution that employment plays in promoting social inclusion goes well beyond its provision of income function. When a person is unemployed, they not only lose their income but are also quickly exposed to a number of other difficulties. Advantages provided by employment, such as contacts with social networks, are lost. Further, the unemployed are more prone to alcohol and substance abuse, involvement in crime, family breakdown and various health problems. According to the 2007 Survey on Mental Health and Wellbeing (ABS, 2008), 29 per cent of unemployed people had experienced a mental disorder in the

previous 12 months, compared to 20 per cent among the employed. Also, the unemployed were almost as twice as likely to have a substance use disorder compared to those who were employed (11.1 per cent and 6 percent respectively).

#### **4.4 Problems of stigma**

Apart from unemployment, the literature widely identifies stigma as one of the most serious barriers to recovery and quality of life of people who experience mental illness. Sartorius and Schulze (2005) for example express concern that stigmatisation with respect to mental illness is growing, regardless of the progress in psychiatry. They further state that negative attitudes towards the person who experienced mental illness persist even after recovery, and after it has been shown that the person could successfully participate in society.

Leff and Warner (2006) also recognise attitudes of the public and stigma as one of the main barriers to social inclusion of people with mental illness. The study states that members of the public perceive people with mental disability in a different way compared to people with physical disability. People with serious mental illness are often viewed as violent and consequently rejected by the public. As a result of a negative public attitude towards them, mentally ill persons have a high propensity to a social isolation. They also have a tendency to integrate within a group of people with similar health problems. Once they are segregated into this social group, it is a very difficult for them 'to break out this social ghetto' (Leff and Warner, 2006:3).

A negative self-image contributes more to the social isolation of people with mental illness and often leads to depression and loss of motivation to fulfil their aspirations. Persons with mental disabilities often have low self-esteem and this reinforces the likelihood that they will withdraw from engaging with the general community. Discrimination in housing, employment and high levels of poverty prevent successful integration of people with mental illness within society. Local communities tend to discriminate against people with mental illness, particularly those who are discharged from long-stay care in psychiatric hospitals. Local communities tend to be reluctant to accept that mentally disabled persons should live within their neighbourhoods (Leff and Warner, 2006).

We argue that, in order to achieve the goal of socially inclusive society, the government should guarantee a job for everyone who is willing to work. In addition, the social inclusion agenda should involve a set of measures for achieving better public attitudes towards persons with mental illness.

### **5. Combating social exclusion**

#### **5.1 Legislative approaches to social inclusion**

There have been various approaches to reducing social exclusion of people with mental illness advocated in the literature. Sayce (1999) for example, suggests a combination of legal reform, public education and local initiatives as the most effective way to deal with the social exclusion of people with mental illness. The Disability Discrimination Act should include a broader definition of disability and provide a greater level of protection for people with mental health problems. It should specifically cover psychiatric as well as other types of disabilities. Public educational campaigns need to be undertaken in order to influence public opinion about mental illness. With this issue, local initiatives are likely to be more effective than national campaigns. Clinicians and voluntary organisations could play a significant role in

influencing public attitudes about people with mental health problems. For example, clinicians working in liaison with other doctors could ensure that people with mental illness have access to good physical care as well as psychiatric care. Voluntary organisations could provide support for people with mental illness to engage in various activities within community.

The above measures would certainly be helpful in reducing discrimination towards people with mental illness. However, they are insufficient to secure their full social integration unless there are enough jobs available and accessible at all times.

## 5.2 The Full Employment

We recognise unemployment as being the major factor of social exclusion and hence employment as the prerequisite for social inclusion. However, Active Labour Market Policies (ALMP) have proven unsuccessful in providing employment for everyone who wants to work. Instead of the direct provision of jobs, ALMP are designed 'to increase the employability of the unemployed and to increase labour supply regardless of persistent demand deficiencies'. Under ALMP, the unemployed are required to intensively search for a job, undertake training and unpaid work. At the same time eligibility criteria for receipt of social security benefits are becoming increasingly rigorous (Cook, 2008: 3).

Mitchell and Muysken (2008) among others (for example, Wray, 1988) argue that an essential goal of macroeconomic policy is to achieve full employment. They argue that this alone will go a long way to achieving the goal of social inclusion for all citizens. They outline a policy framework for full employment and price stability which requires the introduction of a Job Guarantee (JG).

After the Second World War, full employment was the major macroeconomic goal of Australian and other OECD Governments. Until the mid-1970s, most of the Governments were successful in achieving this goal. This was possible by maintaining a sufficient demand using 'counter-cyclical budget deficits and appropriately designed monetary policy' (Mitchell and Watts, 2002: 4) and by maintaining a 'buffer stock' of low skilled jobs mostly in the public sector (Mitchell, 1998).

However, from the mid-1970's government's policy priorities shifted from dealing with unemployment to keeping inflation at low levels. Hence, the concept of full employment had been rejected and is now defined as '...the rate of unemployment that was politically acceptable, given the accompanying inflation rate'. A new term, Non-Accelerating-Inflation-rate of Unemployment (NAIRU) was introduced in the 1970s as synonymous with full employment. Non-voluntary unemployment does not exist. The existing unemployment is a result of individuals' preferences between employment and leisure time. (Mitchell and Watts, 2002: 5).

During the last 30 years, due to restrictive fiscal and monetary policy in most OECD countries, the creation of jobs has been insufficient to meet the growth of the labour force. Thus, unemployment has increased. Furthermore, the preferences of those employed have not been met, as there are not enough working hours. (Mitchell 1998, Mitchell and Watts 1997, Mitchell and Mosler 2001, Mitchell and Muysken 2008). Mitchell (2001: 26) argues that '...all the labour market and related supply-side reforms that have been introduced in Australia...' were unsuccessful in lowering unemployment. The same study finds that the main reason for high unemployment is insufficient demand. 'Unemployment therefore occurs when net government spending

is too low to accommodate the need to pay taxes and the desire to net save. In general, given that the non-government sector desires to hold currency, deficit spending is necessary to ensure high levels of employment' (Cowling and Mitchell, 2002: 7).

'The solution to persistent unemployment is for the Government to act as a Buffer Stock Employer ..'(Mitchell and Watts 1997: 1). The 'buffer stock' of jobs would provide jobs that are always available and be easily accessible by the least skilled and disadvantaged workers in the labour market.

### 5.3 The JG for people with a psychiatric disability

Bill *et al* (2004), propose a JG for people with a psychiatric disability. Under this proposal, any person with mental illness capable to work will be able to get a job and be paid a Federal minimum award wage. However, the Federal Government will need to maintain a 'buffer stock' of creatively designed jobs suitable for people with a psychiatric disability. Urban renewal projects and environmental projects would be perfect for such jobs. Being included in the JG scheme, people with mental illness will be given the opportunity to improve their health as well as to contribute to the community's well being.

For those willing to work, the JG scheme would provide a flexible number of working hours from full-time down to the lowest fraction desired by the worker. Given the episodic nature of mental illness, the ability to voluntarily choose working hours would be particularly important. Furthermore, training initiatives are not excluded from the JG scheme. Current neo-liberal policies through different active labour market programs, such as unemployment training programs and other initiatives, are orientated towards getting the job seeker employable and ready for work if the jobs occur, rather than providing them with the jobs. The JG scheme is actually concentrated on providing the job first, and within paid work, workers could obtain necessary skills. 'Specific skills are usually more efficiently taught on the job' (Mitchell and Muysken, 2008: 15).

## 6. Conclusion

Unemployment is identified as the major factor that leads to social exclusion of people with mental illness and a number of other disadvantages. Thus, provision of a paid job is a prerequisite for the successful social integration of these people. ALMPs which have concentrated on getting job seekers ready for work in case there are jobs, have failed to reduce social disadvantage. Training and career development is most effective in the context of paid employment. To achieve the aim of social inclusion, an alternative to current macroeconomic policy would be to use the fiscal powers embodied in the sovereign government to introduce a full employment and price stability framework using employment guarantees.

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