Improving social and economic participation for young people experiencing depression and anxiety

Jeremy Davidson-Tear

Bachelor of Social Work (UNSW), Bachelor of Arts, Journalism (Uni SA)

School of Social and Policy Studies

Faculty of Social and Behavioural Sciences

Flinders University

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SUMMARY

This research focusses on the contemporary Australian social environment and younger people of working age (16-24 years). The research investigates the high prevalence of depression and anxiety disorders and the relationship between these mental health disorders, long-term unemployment and social exclusion. The issue of social exclusion is seen as having significant implications for current and future economic and social development. Demographic trends indicate a steady increase in the proportion of people retiring and relatively fewer people of working age. Any impediments to participation in education and employment by young people therefore represent a potentially significant loss to the productive output of the nation, as well as entrenching disadvantage for individuals and communities.

Key areas of research include current policies and provisions for income and participation support and how these could be better integrated with clinical mental health and social support services. The focus is on the 'hidden' population of young Australians who are unemployed, receiving minimal or no income support, not in education and training, or in casual and/or insecure work.

The research is topical, as policies over the past two decades have tended to increase restrictions and conditions on younger peoples' access to income support, education and training. The most recent (2015) Federal Budget has continued this trend, with proposals to increase the age for access to unemployment benefits and strict preclusions and obligations for receiving such support for individuals under 30 years of age.

The research examines existing knowledge about the association between unemployment and poorer mental health. It investigates the proposition that unemployment and lack of participation in work or education, particularly when associated with mental health disorders, is likely to result in long-term social exclusion and disadvantage. The research incorporates quantitative data about the population and analyses how the problems of mental health disorders and unemployment are represented, with suggestions for further research and policy development.

DECLARATION

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

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1. INTRODUCTION – WHY THE RESEARCH TOPIC WAS CHOSEN AND WHY IT MATTERS

1.1 Social Work practice and the identification of a problem

I developed the preliminary ideas for this research in 2000 when I was employed as a senior social worker with Centrelink, the Commonwealth agency responsible for payment of income support to individuals and families. At this time people receiving unemployment benefits (Newstart Allowance and Youth Allowance) were subject to strict sanctions if they failed to comply with the conditions of receiving payment. These sanctions, known as 'breaches', were imposed if an individual failed to attend interviews and other prescribed activities.

Two cumulative breaches would reduce fortnightly payments for up to six months, whilst a third breach within a two year period resulted in complete cancellation of payments for eight weeks. A number of welfare advocacy groups and charities were highly critical of this regime, particularly in regard to the proportionality of the sanctions and their effect on people who were already poor and marginalised. A number of nongovernment agencies commissioned an independent panel to review the breach penalties (Pearce et al 2002).

Following the publication of this review the Government declined to change policies or the penalties, but agreed that Centrelink would offer a social work interview and assessment for any individual facing the implementation of a third breach (McDonald & Marston 2006).

Over the next few years, I and my staff interviewed dozens of clients and almost always would ensure that the penalty was not imposed, with referrals made within the agency or to other services. The brief assessments and interventions identified a number of common issues experienced by this client group. Most (more than 90%) were male, usually aged from late teens to early 30s and had come from fractured or blended families, with poor current relationships with parents and siblings. There was a low level of formal education, such as completion of Year 12. All had been unemployed for more than a year, some for several years; where the person had been

employed, work was usually low paid and insecure. Questions about general health indicated indifferent physical health, poor diet and sleep; these discussions about health frequently identified a history of alcohol and/or illicit drug use. The most common drug used was cannabis, with habitual or daily use beginning in adolescence.

During the period from 2000 until 2008 Australia experienced significant growth in employment participation. However, it could be said of the above group of clients that their personal and social circumstances rendered them effectively 'unemployable', regardless of the economic climate. Very few appeared to have any assistance in addressing past and present adversity and many acknowledged that their drug use was a form of self-medication. It was difficult not to conclude that there was a high incidence of mental distress, i.e. anxiety and/or depression, albeit never formally identified or assessed. The question therefore arose: were the mental health issues a *cause* or a *consequence* of long-term unemployment and social exclusion, or indeed both?

1.2 Mental health policy – better outcomes or just good intentions?

From 2007 until 2009 I was employed as the Mental Health Development and Liaison Officer (DLO) for General Practice South Australia, the coordinating body for locally-based Divisions of General Practice. The Commonwealth Department of Health and Ageing had funded the Divisions to provide support and professional education for General Practitioners (GPs). A DLO position was established in each State and Territory following the introduction of the Better Outcomes in Mental Health Care initiative in 2002.

The Better Outcomes initiative, also known as Access to Allied Psychological Services (ATAPS), trained and funded general practitioners to provide mental health care to individual patients. GPs could also prepare Mental Health Care Plans to enable referral to mental health clinicians employed by the Divisions of General Practice who would provide sessional therapies.

In late 2007, the Commonwealth Government introduced the Better Access to Mental Health Care program. This extended Medicare rebates to accredited mental health clinicians (psychologists, social workers and occupational therapists). Better Access also provided rebates to all registered GPs for preparation of Mental Health Care Plans which were required prior to referral to a mental health clinician.

Both initiatives addressed longstanding shortcomings in mental health service provision, particularly for people experiencing such disorders as anxiety and depression who did not require inpatient treatment or who could not afford private specialist services such as psychiatry.

This being acknowledged, I identified a number of concerns which informed the choice of the current research topic and which will be further discussed and analysed:

- The primary focus of care is on individual issues and may not sufficiently acknowledge the contribution of social and economic disadvantage to mental health disorders
- A limited range of therapeutic approaches are sanctioned, with a strong emphasis on Cognitive Behavioural Therapy
- Ready access to GP services is by no means guaranteed, particularly in rural and outer metropolitan areas
- Many GPs and clinicians have limited knowledge and understanding of the experience of long-term unemployment and living on social security benefits
- A relatively small proportion of Better Access services are 'bulk billed', therefore poorer patients/clients are less likely to use services because of 'gap' fees

The first of the dot points above introduces a key element of the research which will be further discussed in Chapter 2. This is the location of mental health within the context of **public health** – that is, that individual well-being is significantly influenced by familial, social and economic circumstances. Fisher and Baum (2010) argue that **the social determinants of mental health** should be considered in the same way that the World Health Organisation considers the social determinants of physical illness and disease (WHO 2002).

The research does not aim to downplay or dismiss the individual experience of mental distress. It does, however question the emphasis on medical, pharmaceutical and therapy-based solutions to anxiety and depression. It is appropriate to consider the causes of distress, including unemployment and social exclusion. For example, the most recent National Mental Health Survey found that mental disorders are experienced by 20% of people who are employed and 29% of the unemployed population (Australian Bureau of Statistics 2007).

1.3 Being a voice for the union

A third set of experiences also contributed to the choice and the scope of the research. While working at Centrelink I undertook the voluntary role of national delegate for Centrelink professional officers (social workers and psychologists) who were members of the Community and Public Sector Union (CPSU).

In 1999 the Commonwealth Government commenced a process of 'Welfare Reform' with a strong focus on improving the social and economic participation of people receiving income support (Reference Group on Welfare Reform 2000). As a member of the CPSU Community Services Executive, opportunities arose for me to develop the union's input to the initial public consultations. This was not without challenge in terms of persuading my colleagues that we should attempt to represent the interests of the Centrelink 'customers' - income support recipients - as well as our members, the agency staff.

The policy reform program was branded as 'Australians Working Together' (AWT) and commenced in 2001 (Centrelink 2001). The target populations were older people of working age, indigenous Australians, parents of school age children and people who had claimed long-term 'incapacity' exemptions from looking for work. Centrelink recruited an additional 1200 'Personal Advisers' whose role was to negotiate individual 'participation plans'. These plans could be highly flexible and include job search activities, education and volunteer work.

Centrelink and the central policy departments, including Prime Minister and Cabinet, were keen for AWT to be broadly supported and consultation arrangements were established between CPSU and senior executives (CPSU: author's documents 2001-2003). This was no small thing in the contemporary political climate, as the then Coalition government did not generally engage with trade unions. I subsequently became a member of the joint union/agency job design committee and the sole CPSU representative on the national AWT implementation group. I was therefore fortunate to be able to provide practitioner expertise at a national level and was able to influence issues such as the boundaries of the adviser role, workplace relations and the incorporation of modules on mental health and domestic violence in the AWT training curriculum.

My role in various committees and conferences afforded me a unique opportunity for freedom of thought and expression. Senior public service managers are in general conservative and cautious and most of those involved in the AWT implementation had limited or no direct contact with Centrelink clients. Faced with the challenge of developing new ways of engaging with clients and changing staff and client behaviour, they were generally responsive to suggestions for creative and inclusive solutions.

I believe this experience was invaluable in the genesis of my current research and its location within a policy and service delivery framework. I consider that the AWT initiative was for the most part benign and genuinely concerned with re-engaging marginalised citizens. Issues concerning welfare and the income support system cannot always be considered according to neat ideological lines - this will be further explored and discussed in the research. Equally, there can also be considerable professional dilemmas working within the constraints of a social security system which has increasingly focussed on 'mutual obligation' as a precondition for receipt of basic income support (Ziguras et al 2003).

1.4 Why this research matters

According to official data, Australia has a relatively low rate of unemployment in comparison to most other developed economies. For example, in 2015 the average Australian rate was 6.3%, whereas in the 18 countries in the Euro currency zone the rate was 11.5% (Australian Bureau of Statistics 2015, Organisation for Economic Cooperation and Development 2015).

The employment/unemployment situation for young people in Australia is less reassuring. A recent Council of Australian Governments report found that 27% of 17 to 24 year olds are not engaged full-time in employment or education (COAG 2013). The unemployment rate for this group is at present close to 14%, whilst in some areas including Northern Adelaide the rate is 20% or more (Brotherhood of St Laurence 2014).

A major contributor to youth unemployment is the lower number of job vacancies suitable for young and inexperienced workers. Other explanations can also be considered, including the lack of large scale apprenticeship and training programs by governments, utilities and business; the declining number of entry level 'unskilled' jobs in manufacturing and primary industry; and local economic variables. A more recent phenomenon is the high cost of housing and transport which may preclude young people taking up job opportunities in more prosperous and expensive metropolitan areas. The other factor driving the low level of fulltime participation in work or education is underemployment – many jobs being part-time, casual and insecure (Vandenbroek 2014).

One might imagine that, given this fairly grim scenario for younger people, there might be a concomitant increase in the level of social and financial support available to them. This does not appear to be the case. Arrangements for younger people's access to income support are particularly restrictive. The 'Common Youth Allowance' introduced in 1997 merged a range of income support payments for students and unemployed people aged under 25 years and disability support pensioners under 21 years (Ey 2012). The actual level of payment received is subject to a family means test

unless the individual can establish that they are independent from the parent(s). The maximum amount of Youth Allowance is lower than Newstart Allowance. The means test also precludes or reduces payment and is applied on fairly modest parental incomes.

During the late 1990s and early 2000s, when there was public consultation on broader welfare reforms, the concept of 'mutual obligation' was applied to younger jobseekers. The newly privatised Job Network employment services were given the authority to recommend breaches to Centrelink as part of their contractual requirements. The anachronistically titled 'Work for the Dole' program was introduced in 1998 (Borland & Tseng 2003). People under 30 who had been unemployed for more than six months were required to undertake work in community organisations and projects in order to continue to receive income support, for which they received a supplement of $20 per week to cover transport and other expenses. The Work for the Dole program was ceased by the Labor government elected in 2007.

The Federal Budget in May 2014 proposed significant changes to income support for younger people. The changes included reintroducing Work for the Dole, 'waiting periods' of from six to twelve months before unemployed people under 30 could access payments and strict requirements in regard to job search and participation. The 2014 proposals did not pass into legislation and were presented in a modified form in the 2015 Budget (Department of Social Services 2014; 2015).

I would suggest that successive policy decisions have been based on a number of assumptions about younger people. These include the notion that parents should in most cases be responsible for supporting young adults and that younger people require compulsion to 'earn or learn'. There appears to be little recognition of high levels of youth unemployment, particularly in outer metropolitan and rural areas.

In regard to the research question, a significant issue is the high prevalence of anxiety and depression in people aged 25 and under. The Australian National Survey of Mental Health and Wellbeing found that 26% of people aged 16-25 years had experienced a

mental disorder in the 12 months prior to the survey (Australian Bureau of Statistics 2007).

A major challenge in undertaking this research is the complexity of health and welfare policy and service provision. At the national level, a number of Commonwealth Departments are responsible for the policy matters, funding and service delivery which affect the population which will be the subject of the research.

The hypothesis for this research is that there is an absence of integrated policy across agencies and portfolios (e.g. health, employment and social security) in regard to the population group. The associations between unemployment, mental health and social exclusion have been noted in strategies such as the National Mental Health Plans, but to date there has been little in the way of policy and program development to address these issues in a coordinated fashion.

The shortcomings in providing effective help and support for young Australians are likely to perpetuate disadvantage across generations:

> The substantial rise in youth unemployment…should be of deep concern to policy-makers, jobs services and charitable sectors and the broader community. An extended period out of the workforce for a young person in this most formative period of their lives places them at risk of a life sentence of poverty and exclusion from the mainstream of our society (Brotherhood of St Laurence 2014, p6).

The Literature Review will therefore explore a range of domains, including data on youth unemployment and mental health, policy and programs and research on the associations between unemployment and poorer mental health.

Given the complexity of life events that effect young people's well-being and social inclusion, the research will not attempt to describe issues of cause and effect. Nevertheless, it is important to understand the characteristics of the population of younger Australians, including the apparent high prevalence of anxiety and depressive disorders. The research will examine this prevalence, and associated factors of social exclusion and disadvantage, in attempting to understand their effects on individuals' ability to participate in employment or education.

The methodology will utilise both quantitative and qualitative data to address the research question. The research is a secondary analysis of data from a wide range of sources, including current and recent policies in regard to mental health, unemployment and income support.

A key component of the critical analysis of the data will be how the problems of youth unemployment and mental health are portrayed and represented (Bacchi 2009). The intent of recent actual and proposed policies affecting younger unemployed people, as described above, would seem to suggest that the problems are intrinsic to that group; therefore young people require compulsion to obtain work and restrictions and limitations on income support will provide additional motivation to do so.

The research will investigate what is known about the extent of unemployment in the younger population and the interrelationship of other adversities of disadvantage such as mental health disorders, comorbid alcohol and drug use, and poverty. It will be argued that what is not known or sufficiently understood about this population perpetuates a distorted representation of their actual circumstances. This, in turn, leads to simplistic policy responses and limited ideas for alternative approaches to policy and service provision.

2. THE LITERATURE REVIEW

2.1 Introduction and overview

Evidence from both government and nongovernment organisations supports the need to focus the research on young people aged 16-24 years, given the frequency of onset of mental health disorders at this life stage and the associated disadvantages such as unemployment and non-completion of education (Brotherhood of St Laurence 2014; Council of Australian Governments 2013; Australian Bureau of Statistics 2007).

The research explores a range of data about this population and what is known about factors of social exclusion, including apparent significant gaps in knowledge and service provision. Much of the data is readily accessible, for example statistics about unemployment, income support payments and prevalence of mental health disorders.

Additional quantitative data include existing research on mental health and employment (Harnois and Gabriel 2000; Department of Education, Employment and Workplace Relations 2008). Departmental and program evaluations were also examined.

The theoretical perspectives of the social determinants of mental health and social inclusion will be used to guide the interpretation of data (Saunders 2011; Fisher & Baum 2010). Contemporary discussion of social exclusion in Australia is highly relevant to the research as it examines disengagement, exclusion from basic services and economic exclusion. Particular consideration will be given to research that investigates the importance of participation (inclusion) for young people making the transition to adulthood and independence.

These perspectives provide an initial framework for scrutiny of current policy and service provision. The research will require particular examination of policies and services in regard to how they affect young people and what could or should be improved, especially in regard to improving opportunities for participation (Browne & Waghorn 2010; Orygen 2014).

This Literature Review follows the framework developed by Helen Aveyard (2007). It incorporates the key questions and issues, the hierarchy of evidence, inclusion and exclusion criteria, search strategy and keywords and findings/discussion of key issues.

2.2 Key Questions and Issues

The research subject requires investigation of the policy domains of income security and mental health. The development of services and practices resulting from these are also examined. The questions outlined below provide the initial framework for the focus of the Literature Review:

What is the context (place and time)?

The research will focus on the Australian social context, in particular national (Commonwealth Government) policies and initiatives. The period under investigation will be 1990 until the present day. This choice of time period is congruent with a number of significant changes to the original post World War Two social security system and the development of the National Mental Health Strategy which commenced in 1992.

Some international material is included in the Literature Review where it provides comparative data for consideration of the Australian context. Sources of information include the World Health Organisation (WHO) and the Organisation for Economic Cooperation and Development (OECD).

What population will be studied?

The research will be examining people with high prevalence disorders of depression and/or anxiety as these are said to affect 20% or more of the working population and 29% of the unemployed population (National Mental Health Survey: Australian Bureau of Statistics 2007). Some further exploration of prevalence data will be required, as this survey, which is often referenced, was based on individuals' self-reporting of symptoms.

The selection of people aged 16-24 reflects the data that the onset of these disorders is most likely to occur in adolescence and early adulthood (Council of Australian Governments 2008). The research will investigate the existing evidence that experience of mental health problems at this stage of life will lead to other

disadvantages and poor outcomes in regard to comorbidity, education and social and economic participation.

What is the association between mental health disorders and unemployment?

As noted above, mental health disorders appear to be more prevalent in the unemployed population. Psychological or psychiatric disorders have been the most common conditions for which the Disability Support Pension (DSP) is granted - 31.3% of DSP recipients (Department of Social Services 2013). Revised criteria for DSP eligibility and recent proposals for welfare reform are likely to restrict access to income support payments by younger people experiencing mental health disorders (Department of Human Services 2014). However, there appears to be a significant gap in policies addressing the material and social supports required by young people to enable them to participate in employment, education and training.

The research will examine issues of cause and effect – does being or becoming unemployed cause disorders, or are young people with pre-existing conditions much more likely to not be able to gain or sustain employment? The Literature Review will identify what is known about other contributing or associated factors, which may include socio-economic disadvantage, poor education attainment and comorbidity (poor physical health and wellbeing and/or substance misuse).

Social inclusion or social exclusion?

A guiding principle for the research is social *inclusion*:

> "Social inclusion recognises that many Australians are excluded from the opportunities they need to create the life they want, and can become trapped in spirals of disadvantage caused by family circumstances, low expectations, community poverty, a lack of suitable and affordable housing, illness or discrimination – often leading to leaving school early, long-term unemployment and chronic ill-health" (Australian Social Inclusion Board 2008).

The above statement identifies factors of *exclusion* which will require exploration and examination. The Literature Review will examine data such as access to income support and mental health services and will also identify research and policy analysis regarding social inclusion and exclusion.

What is missing?

The research methodology will use the WPR - 'What's the problem represented to be?' - approach to policy analysis. A key element in this framework is identifying what "is left unproblematic" in the representation of a problem, where are the "silences" and how problems may "be thought about differently" (Bacchi 2009).

The WPR framework offers a useful conceptualisation of problems associated with social exclusion. A recent Council of Australian Governments report found that 27% of 17 to 24 year olds are not engaged in full-time employment or education (COAG 2013). So is it possible that this group, or a significant proportion of the group, experience social exclusion largely as a consequence of this lack of participation in employment, education or training? What is known about their circumstances and how they are supporting themselves, their mental health and access to income and other support? And perhaps some young people, for example those who are precluded from receiving income support by family and other circumstances, are so excluded as to be off anyone's radar.

The evidence from this Literature Review has identified a wealth of data about the high prevalence of anxiety and depression in the population of younger people. There is also a significant body of research about the detrimental effect of unemployment and job loss on mental health. Some work has particularly focussed on the long-term impact of unemployment when experienced early in life (Strandh et al 2014; Fergusson et al 2001). In contrast, there appears to be comparatively little work that identifies the consequences for young people experiencing anxiety and depression in regard to their participation in employment and education. This gap in knowledge and policy and service development will be further explored later in this chapter.

2.3 The Hierarchy of Evidence

There are five categories of evidence which form the Literature Review:

- Existing research relevant to the identified population and topic
- Documents relating to Australian policy
- Australian population data
- Information from nongovernment organisations (NGOs)
- Popular literature

Existing research

This includes peer-reviewed research specific to mental health disorders, levels of unemployment or underemployment and other issues including comorbid substance misuse. Also included is research into factors related to social exclusion and related government or official reports, including investigations or surveys commissioned by government agencies or NGOs. International research is considered where it is relevant to the Australian context.

Policy documents

These are drawn from Commonwealth Government and other national sources such as COAG. Documents include legislation, departmental guidelines, official reports, parliamentary proceedings and parliamentary committees.

Population data

This material has a specific focus on mental health and includes surveys such as the 2007 National Mental Health Survey and other population health and prevalence data such as Medicare Benefits Schedule statistics. Also included are research from academic institutions and other bodies such as the Australian Institute for Health and Welfare, Social Policy Research Centre, Australian Council of Social Services (ACOSS). As previously noted, international data will be included where relevant to understanding or comparing with the Australian context.

Information from NGOs

There are many organisations concerned with mental health awareness, education, research and service provision. Information is readily available from the internet. Although much of this information will be considered as 'grey literature', some websites include referenced and peer reviewed research and reports.

Information obtained from NGO sources includes general information about mental health disorders and prevalence, program and service information, reports and submissions to governments and conference proceedings.

Popular literature

Welfare provision and mental health issues are subjects of much political and economic debate, even if this is not always well-informed. Contemporary and historical commentaries will be used where they have particular relevance to the research topic and policy formation. Subject to the criterion of relevance, material considered includes books, newspapers and online articles.

2.4 Inclusion and Exclusion Criteria

This research is on contemporary Australian policy and service delivery and therefore will focus primarily on information and data produced from 1990 to the present day. Historical data and perspectives are included where they are relevant to the development of current and recent policies. This work is informed by primary research about anxiety and depression in younger people, comorbid alcohol and other drug use, their participation (or otherwise) in employment or education, and social determinants of mental health.

The scope of this research also includes exploration of income support provided to young people, in particular the increased restrictions on their ability to obtain unemployment or disability benefits. Consideration of income support policy and data about the level of payments is highly relevant to the research topic, as this raises the

issue of whether the social security system actually works to promote better social and economic participation.

The research will not include data prior to 1990, except where the material provides historical context. It will not examine data and research on people with severe and lower prevalence psychiatric disorders or on adults over the age of 24.

2.5 Search Strategy and Keywords

Much quantitative and statistical data is available from Australian Government websites. The Australian Institute of Health and Welfare's 'Mental Health Services Australia' reports provide a valuable digest of service usage by population groups.

Initial searches of databases were 'global', in order not to miss comparative and meta-studies which are relevant to Australia. The databases identified with articles relevant to the topic included ScienceDirect, psycINFO , pubMED and APAFT. ScienceDirect was noted as a particularly useful source as it identified additional articles similar to the item currently being accessed.

The scope of the research covers social policy, mental health, population health, clinical research, income support and employment. Combinations of the following keywords were employed:

- young people
- unemployment
- mental health
- anxiety
- depression
- social determinants of health/mental health
- income support/social security
- social inclusion/social exclusion
- welfare reform
- social psychiatry/social psychology

A number of the initial searches of the literature returned a large number of articles, with a relatively small number being of contemporary relevance to the research topic. A 'rapid review' approach was adopted. Key documents were saved and reviewed in full, with abstracts of uncertain relevance being printed and categorised for further examination. Many references contained in the more relevant articles also provided a rich source of material for further reading and review.

2.6 Findings: Discussion of Key Issues

This discussion is structured in the following categories and topic areas:

2.6.1 The social determinants of health and mental health

- An introduction to the social determinants of health
- The evolution of the concept of social determinants of mental health
- Prevalence data for anxiety and depression in younger Australians and data identifying anxiety and depression separately from serious mental illnesses/disorders
- The literature on social determinants of health and mental health for adolescents and young people

2.6.2 The dimensions of unemployment; income support and employment services for young people

- Examination of current data on youth participation and unemployment
- Features of youth unemployment in Australia
- Evolution in policy since 1990 – the introduction of the Common Youth Allowance, redefining independence and dependence
- Disability Support Pension data and policy relevant to under 25 year olds
- Current proposals for 'welfare reform'

2.6.3 Unemployment and mental health

- Evidence of association between unemployment and anxiety/depression, relevant international data comparative to Australia
- Other factors: mental health and substance use

2.6.4 Policy and services

- Developments in primary mental health care since 1990
- Data identifying young people's use of mental health services
- Discussion and commentary on the medical vs. social construction of mental health

2.6.5 Summary

2.6.1 The social determinants of health and mental health

An introduction to the social determinants of health

At first glance the subject of this research could appear to have some obvious conclusions. Many people who have experienced first- or second- hand the effects of prolonged unemployment would acknowledge the distress this causes. Popular literature in the twentieth century documented the plight of the unemployed worker and the widespread hardship during the worldwide Great Depression of the 1930s. The journalism of George Orwell and the novels of John Steinbeck, for example, described not only the experience of abject poverty but its resultant ill-effects on relationships and individual wellbeing. A social history of the Depression in Adelaide noted that:

> The majority of the unemployed experienced a certain period of anxiety very shortly after becoming unemployed. Whereas most people fairly quickly adjusted to their situation, some were very slow, or never able do so. These people experienced the Depression in a state of more or less continuous anxiety (Broomhill 1978, p73).

In beginning an examination of mental health disorders and their association with unemployment, it is useful to locate the issues within the broader context of public health. The modern concept of public health, or population health, has its origins in the nineteenth century when the control and prevention of disease were addressed by authorities at the community level with improvements in sanitation, water supply, housing and vaccination.

In the latter part of the twentieth century new concepts of public health evolved, with a greater focus on health promotion and a better understanding of the contribution (or otherwise) of social and economic factors to the health of individuals:

> In industrialised countries the behaviour modification approaches to health were developing alongside growing concerns about inequities in health and the failure of health services (even deliberately egalitarian services such as the British National Health Service) to do much about them. The British Black Report on inequities in health was compiled in the second half of the 1970s…and concluded very firmly that, while behavioural factors did play a role in health, they were not primarily responsible for the differences in health status between

> Britons in different social classes. They favoured explanations that lay in the social and economic support available to people and foreshadowed the Ottawa Charter's emphasis on policy as a key strategy for health promotion. So the 1970s saw highly individual, behavioural approaches to health being developed, while social structural causes of illness and health were coming to be understood in more detail (Baum 2008, p.34).

The Ottawa Charter for Health Promotion was developed by the World Health Organisation (WHO) in 1986 and describes a range of strategies to address inequities in health for all nations:

> Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socioecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment…Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable (WHO 1986, p2).

The Ottawa Charter also identifies that health is not just the responsibility of health professionals and health agencies:

> The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organization, by local authorities, by industry and by the media.

This is a key theme for this research and will be addressed in more detail later in this chapter. While individuals of course have a responsibility to maintain their physical and psychological wellbeing, it will be argued that the broader society and economy have a duty of care in regard to the mental health of young Australians. As WHO stated in a later iteration of the social determinants of health framework:

> Life contains a series of critical transitions: emotional and material changes in early childhood, the move from primary to secondary education, starting work, leaving home and starting a family, changing jobs and facing possible redundancy, and eventually retirement. Each of these changes can affect health by pushing people onto a more or less advantaged path. Because people who have been disadvantaged in the past are at the greatest risk in each subsequent

> transition, welfare policies need to provide not only safety nets but also springboards to offset earlier disadvantage (Wilkinson & Marmot 2003, p10).

The evolution of the concept of social determinants of mental health

The practices of psychiatry and psychology focus on individual behaviours and disorders; however definitions of mental illness and mental health can also be viewed within a social and cultural context:

> The contemporary assumption, derived from a scientific-psychological model of mental illness, was that it could be defined and described in terms of a cognitive malfunction. Foucault, however, argued that people were often defined as insane simply because they behaved in ways that were different from the majority or that contravened the norms of polite society (Oliver 2010, p7).

The advances in therapeutic interventions beginning in the nineteenth century were doubtless an improvement on the incarceration, or worse, of people deemed to be 'lunatics' or mentally unwell. In the twentieth century, psychiatric treatment and institutional 'care' were subjected to scrutiny and criticism, not least because of their oppressive nature and the question of whether such care actually worsened people's conditions (Goffman 1961). At its worst, psychiatry could also be used as a form of extreme state control, for example in the former Soviet Union where political dissidents were routinely diagnosed as mentally ill and hospitalised and medicated against their will (Szasz 2009).

In the 1960s and 1970s there was increased questioning of mainstream ideas about mental illness and psychiatric/medical treatments. A group of (mainly) British psychiatrists proposed alternative models and explanations for schizophrenia which became known as 'anti-psychiatry' (Laing & Esterson 1970; Cooper 1971).

The 'anti-psychiatry' movement is noted here for two reasons. Firstly, it is important to distinguish it from the concept of social determinants of mental health – the prime concern of the 'anti-psychiatrists' being to question the diagnosis and interpretation of mental illness:

> We shall use the expression 'schizophrenic' for a person or for his experience or behaviour in so far as he, his experience, or his behaviour, are clinically regarded as betokening the presence of 'schizophrenia'. That is, this person has come to

> have attributed to him behaviour and experience that are not simply human, but are the product of some pathological process or processes, mental and/or physical, nature and origin unknown (Laing & Esterson 1970, p17).

The development of the concept of social determinants of mental health, as discussed below, is by contrast concerned with the social and economic factors that affect individual and community wellbeing. The other reason for noting the work of the 'anti-psychiatrists' is that the movement posed questions about the narrow medical interpretation of mental distress and disorders. This issue will be further explored in the discussion and analysis sections of the research.

The literature on the social determinants of mental health has emerged over the past thirty or so years, following in the train of broader discussion and research on the social determinants of health. A significant element in the literature is the focus on promotion of mental health and not just the treatment of illness or disorders.

The World Health Organisation has identified the importance of mental health as part of good public health, as well as explicitly recognising that the mental health of individuals and communities is affected by economic factors.

> The poor and the deprived have a higher prevalence of mental and behavioural disorders, including substance use disorders. This higher prevalence may be explainable both by higher causation of disorders among the poor and by the drift of the mentally ill into poverty. Though there has been controversy about which of these two mechanisms accounts for the higher prevalence among the poor, the available evidence suggests that both are relevant (WHO 2001, pp. 4-5).

The importance of employment as a factor in maintaining good mental health has also been recognised, as well as the negative effects of unemployment (Harnois & Gabriel, 2000; Broom et al 2006).

In subsequent work focussing on the promotion of positive mental health, WHO argued the case for improvements in policy and service development:

> …research has shown that mental health can be affected by non-health policies and practices, for example in housing, education and child care. This accentuates the need to assess the effectiveness of policy and practice interventions in diverse health and non-health areas. Despite uncertainties and gaps in the

> evidence, we know enough about the links between social experience and mental health to make a compelling case to apply and evaluate locally appropriate policy and practice interventions to promote mental health (WHO 2005, pp. xxviii-xix).

Fisher and Baum suggest that there can be a direct causal link between chronic 'stress arousal' in the social environment and mental health problems:

> Such an explanatory framework may offer some useful perspectives on evidence showing that common mental health problems and disorders are more prevalent among populations subject to forms of socioeconomic disadvantage according to income or education level, or to conditions such as insecure employment, recent unemployment, insecure housing, or unsafe neighbourhoods (Fisher & Baum 2010, p. 1061).

The combination of social disadvantage and poor mental health can also result in apparently intractable problems, as demonstrated in the following statement. While it obviously refers to Aboriginal Australians, the description could easily apply to the situation for young people in other rural and outer metropolitan regions with limited opportunities for employment and education:

> …Indigenous communities are the prime example of the negative social determinants of health in Australia. This reflects the 'chicken and egg' relationship between social determinants and mental health, particularly in small and closed communities. In fact, so interrelated are these problems it is my belief that without addressing mental ill-health and the social determinants of poorer mental health as issues in their own right, efforts to improve life in many Indigenous communities, both urban and remote, are likely to come undone (Calma 2007, p. 6).

While it would appear that a consensus has emerged that mental health and wellbeing is strongly influenced by social and economic determinants, the issue of how best to address problems does not appear to be settled. Larsson identifies a 'rhetoric/reality gap' in government responses to mental health problems. Although there is significant evidence that factors such as socioeconomic status, ethnicity and age influence wellbeing, the usual policy response has been to focus on individual therapies and building 'resilience':

> …it is argued that "resilience against adversity" should serve as a protective factor against mental health difficulties. It is never implied that if an individual is born at the lower end of the socioeconomic scale then the resilience (materially,

> physically and psychologically) needed against adversity may never have been there to begin with (Larsson 2013, p188).

The evidence of the effects of adversity on young people will be further explored in this chapter.

Prevalence data for anxiety and depression in younger Australians and data identifying anxiety and depression separately from serious mental illnesses/disorders

There have been two national surveys of mental health and wellbeing conducted in Australia, the first in 1997 and the second in 2007:

> The 2007 National Survey of Mental Health and Wellbeing (NSMHWB) of adults (ages 16–85) provides information on the 12-month and lifetime prevalence of mental disorders in the Australian population. It was estimated that 45% of Australians in this age range (7.3 million people) will experience a mental disorder at some time in their life (ABS 2008). It was also estimated that 20% of the population (3.2 million people) had experienced a common mental disorder in the previous 12 months (ABS 2008). Of these, anxiety disorders (such as social phobia) were the most prevalent, afflicting 14.4% of the population, followed by affective disorders (such as depression) (6.2%) and substance use disorders (such as alcohol dependence) (5.1%)…
>
> Mental illness also includes 'low prevalence' conditions. This group includes psychotic illnesses and a range of other conditions such as eating disorders, and severe personality disorder (DoHA 2010). Psychotic illnesses are characterised by fundamental distortions of thinking, perception and emotional response. Psychotic disorders include schizophrenia, schizoaffective disorder, bipolar disorder and delusional disorder (Morgan et al. 2011).
>
> (Australian Institute of Health and Welfare 2014, pp3-4)

It will be noted that the terms ‘mental illness’ and ‘mental disorders’ are both used by AIHW in this summary. For the purposes of this research the term ‘mental health disorder’ will be used in reference to the population experiencing anxiety and depression, to distinguish this group from those experiencing psychotic illness. This is not in any way intended to dismiss the severity of symptoms that some people with anxiety and depression have. The use of the term ‘disorder’ acknowledges that people will experience varying degrees of distress from moderate to severe, but may not necessarily see themselves as having an illness. This terminology is seen as

consistent with that used by mental health service organisations, for example, information on the *beyondblue* website refers to anxiety as a disorder and only the more severe forms of depression as illness (*beyondblue* 2015).

A comparison of the relative prevalence of illnesses and disorders is illustrated by AIHW data on service usage. This shows that, for the Financial Year 2011-12, 14,956,000 mental health-related consultations with general practitioners occurred. Generally these consultations with GPs would be for less acute or severe disorders. This compares to 188,739 occasions of service in public hospital emergency departments, most of which are likely to be for crisis or acute presentations (AIHW 2014).

The above statistics are gathered for the whole Australian population and are not broken down into age groups. However, the 2007 NSMHWB did gather age-related data and found that younger people are more likely to experience mental health disorders:

> The prevalence of 12-month mental disorders varies across age groups, with people in younger age groups experiencing higher rates of disorder. More than a quarter (26%) of people aged 16-24 years and a similar proportion (25%) of people aged 25-34 years had a 12-month mental disorder compared with 5.9% of those aged 75-85 years old." (Australian Bureau of Statistics 2007)

This higher prevalence of mental disorders in the younger population is confirmed by data obtained from the Medicare Benefits Schedule (MBS) on the usage of GP Mental Health Treatment Plans (GPMHTP). These consultations are a requirement for referrals to psychiatrists, allied mental health practitioners and ongoing GP care for mental health issues and would usually exclude consumers using hospitals or community mental health crisis services. They are a good indicator of mental health service usage and prevalence in any 12-month period, as only one plan can be completed each year for an individual.

The MBS data for 2012-2013 show that 865,627 GPMHTPs were completed for all population groups. Of this total, 163,912 plans (18.9%) were completed for people aged 15-24, who represent only 13.5% of the Australian population (Department of

Human Services 2014). NB: these data include 15 year olds as the MBS statistics are represented in five-year increments.

These data support the importance of the research focussing on the population aged 16-24 as the experience of mental health disorders combined with other adversities is likely to result in long-term effects across people's lifetimes:

> Young adulthood is crucial for the establishment of psychological well-being in adult life. Decisions and transitions made at this time can have consequences that persist throughout adult life, and transitions in one domain can affect progress in others. If transitions are related to mental health and to psychological development, then transitions that are less than optimal in timing or sequence may have long-term consequences through their influence on mental health as well as on their influence on subsequent transitions (Lee & Gramotnev 2007, p878).

The literature on social determinants of health and mental health for adolescents and young people

The data and literature described so far might be viewed as somewhat unsurprising – adolescence and the coming of age into adulthood will inevitably involve a degree of emotional turmoil and uncertainty. The pertinent question for the research relates to matters of degree. As illustrated by the previous quote, transitions that are unsuccessful or fraught by adverse circumstances are likely to have long-term negative consequences for individuals.

The initial identification of the broad social determinants of health (SDH) has inevitably led to consideration of the issues in regard to age, gender and ethnicity. Much of the research and literature on SDH for young people is relatively recent and post-dates the Ottawa Charter. A significant proportion of the material investigating health issues for adolescents and young adults reflects contemporary concerns about risk and lifestyle, in particular nutrition, physical activity, substance use or misuse (including alcohol and tobacco), sexuality and HIV/AIDS.

As might be expected, further development on SDH (and mental health) has been driven by the World Health Organisation (WHO). The World Health Report (WHO 2001) was dedicated to a wide-ranging investigation of mental health policy and

practice and acknowledged the importance of health promotion, prevention and the alleviation of social and economic factors contributing to mental ill-health. A later report on prevention and promotion in mental health (WHO 2002) specifically identified public health measures for young people, including school-based programs to promote resilience and life skills, and interventions to reduce the incidence of anxiety and depression. WHO has further explored and identified Issues of promotion of 'positive' mental health and resilience, with particular emphasis on the onset of mental disorders early in the life course and the need to focus support and intervention on younger people (Friedli 2009).

Beginning in the 1980s, WHO coordinated the Health Behaviour of School-aged Children (HBSC), a transnational series of studies to promote the health and wellbeing of young people. The HBSC studies include examination of a wide range of social and material determinants of health. More recently, particular attention has been given to mental health issues for adolescents and processes for engaging young people themselves in identifying issues such as bullying in schools (Koller et al, 2009).

There are significant challenges in addressing SDH for younger people when viewed against global issues of poverty, inequality, conflict and environmental degradation. It could be easy to portray these issues, which affect not only the young, as intractable and simply too big and too hard to fix. A way forward has been suggested that emphasises practical action:

> The strongest determinants of adolescent health worldwide are structural factors such as national wealth, income inequality, and access to education. Furthermore, safe and supportive families, safe and supportive schools, together with positive and supportive peers are crucial to helping young people develop to their full potential and attain the best health in the transition to adulthood. Improving adolescent health worldwide requires improving young people's daily life with families and peers and in schools, addressing risk and protective factors in the social environment at a population level, and focusing on factors that are protective across various health outcomes. The most effective interventions are probably structural changes to improve access to education and employment for young people and to reduce the risk of transport-related injury (Viner et al 2012, p 1641).

These authors suggest that the SDH can thus be categorised into 'structural' and 'proximal'. The proximal factors are those in the local environment and experience of people. While obviously determined to a degree by global and national factors they can also be influenced by action at a community and individual level.

This concept is central to the scope of this research. The population being studied are clearly affected greatly by economic factors and national policies in regard to income support and health provision. An examination and questioning of these forces is required, as is also an exploration of what can be achieved at the community and individual level with improved services and opportunities for participation.

One notable study has explored SDH through the 'life course'. The Christchurch Health and Development Study (CHDS) researched a cohort of more than 1,000 people born in New Zealand in 1977 and studied individuals' development and wellbeing at a number of life stages from early infancy to adulthood. Data obtained from the study incorporated physical and mental health, behavioural issues and educational and employment outcomes.

The CHDS data have generated a large number of research papers and the study is frequently cited by other researchers. The association between unemployment and anxiety disorders was noted in a study of the cohort at age 18 (Fergusson et al 1997). Those who had experienced anxiety disorders in adolescence were more likely to continue to experience anxiety and other adverse outcomes in adulthood (Woodward & Fergusson 2001); those diagnosed with depression in adolescence were found to be at increased risk of continuing to experience major depression and anxiety (Fergusson & Woodward 2002).

From the perspective of SDH, the CHDS was less conclusive about some of the long term effects on those in the cohort who experienced poverty in childhood:

> …after due allowance has been made for social, family and individual contextual factors, low family income during childhood is associated with a range of educational and economic disadvantages in adulthood but is not directly related to increased risks of crime, mental health problems or teen pregnancy (Gibb et al 2012, p 1789).

Family income alone may not be a singularly reliable indicator for SDH – as can be seen from the above, social and family factors have been allowed or adjusted for. Other factors that may be associated with lower income or poverty, such as family breakdown or domestic violence, are likely to have significant negative effects on children and young people. As one commentary on Gibb notes:

> …parental mental illness might be an unmeasured prior common cause of family income and offspring's mental health problems (Gilman 2012, p 2126)

The work undertaken by WHO and others demonstrates that the health of adolescents and young people is strongly influenced by social and economic determinants. The CHDS, whatever its perceived limitations, adds value in illustrating both the structural and proximal factors of SDH in the life course.

The National Mental Health Commission, established in 2012 by the Commonwealth Government, has drafted an agenda for comprehensive reform of mental health services (NMHC 2014). The strategy recommended by the Commission is for a 'person-centred' system of care which is calibrated to individual needs. One of the four principles underpinning this approach is the addressing of social and economic determinants of mental health, including housing, education and employment support.

2.6.2 The dimensions of unemployment, income support and employment services for young people

Examination of current data on youth participation and unemployment

The rate of unemployment in Australia is measured as the proportion of people unemployed out of the total population of 'working age' 16-64 years old. The Australian Bureau of Statistics (ABS) conducts monthly surveys and will classify a person as unemployed if they meet three criteria:

- not working more than one hour in the reference week;
- actively looking for work in previous four weeks; and
- be available to start work in the reference week (ABS 2014).

ABS acknowledges that this single survey methodology has some limitations, notably in regard to underemployment. The ABS Survey of Income and Housing (SIH) measures the number of people working part-time who would work more hours if the work was available, and those working fewer hours because of stand-downs or shortage of work. According to the most recently available SIH data:

> In May 2013, about 900,000 employed people were underemployed (trend); which was around 30% higher than the number of unemployed people. The underemployment rate (that is underemployed as a proportion of the labour force) was 7.3%. Combined with unemployment at that time, 12.8% of the labour force was underutilised (ABS 2013).

ABS also acknowledges that the extent of unemployment is not accurately represented by the number of people who received income support in the form of Newstart Allowance (NSA) or Youth Allowance Other (YAO – for those people under 22 not in full-time education):

> …not all people receiving NSA or YAO were classified as unemployed according to the ABS definition. In 2011-12, just over one-third (36%) of these recipients were defined as unemployed, with the remaining recipients classified as employed (26%) or not in the labour force (38%). Furthermore, the SIH estimates that only 30% of all unemployed people were receiving NSA or YAO in 2011-12 (ABS 2013).

For this research it is important to consider the broader participation by young people in education and training. As might be expected, many 16 and 17 year olds are at school, particularly in the states and territories with a mandated school leaving age of 17 (ACARA - Australian Curriculum, Assessment and Reporting Authority - 2009).

The numbers of people participating in study for a qualification are reported by the Australian Institute of Health and Welfare. This report includes young people working towards completion of Year 12, vocational certificates and tertiary study. In 2013, 80.3% of the population aged 15-19 years and 40.9% of 20-24 year olds were in this category (AIHW 2013).

Data from the Council of Australian Governments show a somewhat different picture, reporting that more than one quarter (27%) of 17 to 24 year olds are not engaged full-time in either employment or education (COAG 2013). These data could be interpreted in a number of ways – it is possible that some (or even many) young people are satisfied with part-time work or education, or a combination of both. Equally, a proportion of this 27% would be unemployed and not participating in any education or training and others would be in the category of underemployed. For the purposes of the research question the nature and dimensions of youth unemployment in Australia were investigated.

Features of youth unemployment in Australia

Australian population data for 2014 record that approximately two-thirds (65.4%) of the population is comprised of people of working age. Working age is defined as 16-64 years old; while people can be legally employed at 14 or 15 years, 16 years is the age at which a person can claim income support in their own right. The younger cohort of 16-24 year olds represents 18.6% of the working age population and therefore nearly one-fifth of the national labour market (ABS 2015).

Unemployment benefits data (people receiving NSA or YAO) show that the cohort of 16-25 year olds represent 24.2% of all people aged 16-64 receiving payments. This indicates that a higher proportion of young people are receiving unemployment income support relative to their numbers in the working age population (DSS 2015).

The duration of unemployment is also notable. Of 104,916 people under 25 receiving benefits, 63,678 – 60.7% - were unemployed for 12 months or more. This group represents 23.1% of all benefit recipients considered as long-term unemployed (DSS 2015). However, in regard to younger people with long term disabilities or illness, including serious mental health disorders, it is noted that of 827,460 recipients of Disability Support Pension, only 5.6% are under 25 (DSS 2013).

The primary factors affecting unemployment among all age groups are economic. This can be seen by events following the global financial crisis of 2008-2009, with average rates of unemployment in the 28 European Union (EU) countries rising from 7.0% in 2008 to 10.8% in 2013. The most economically vulnerable nations experienced very sharp rises in unemployment during these six years: Greece (7.7% to 27.3%), Spain (11.3% to 26.1%) and Portugal (8.5% to 16.5%) (European Commission 2015).

Youth unemployment in these more vulnerable economies is considerably higher. The International Monetary Fund reports that in 2014 youth unemployment in a number of EU countries is more than 50%, and only 4 in 10 workers between the ages of 15 and 24 are employed (Banerji 2014).

Australian statistics show significant regional differences in unemployment rates. While the national average rate of unemployment in 2015 was 6.3%, the provincial rate varies from 4.3% in the Northern Territory to 6.4% in South Australian and 6.6% in Queensland and Tasmania (Department of Employment 2015).

As noted above, the average rates of youth unemployment in Australia are significantly higher than for the total working age population. The Brotherhood of St Laurence (BSL) has recently campaigned on the issue of youth unemployment and mapped what are referred to as the worst regional hotspots for youth unemployment, based on ABS data. Among the worst areas are North and North West Tasmania (21%), Cairns (20.5%), Northern Adelaide (19.7%) and Outback Northern Territory (18.5%). It can be concluded that these figures are a direct reflection of the decline of regional manufacturing and processing industries, in the case of South Australia and Tasmania, or remoteness in the case of the Territory. These figures for youth

unemployment compare unfavourably with the State and Territory overall averages for unemployment, for example the Australian Capital Territory has a youth unemployment rate of 11.3% compared to an overall unemployment rate of just 4.4% (BSL 2014).

Australia has a culturally diverse population. Given the number of different ethnicities and groups and dynamic patterns of migration and settlement, it has been difficult to obtain much literature about ethnicity as a factor contributing to youth unemployment. However, in regard to unemployment within the general migrant population, the Federation of Ethnic Communities Councils Associations (FECCA) has reported that during economic downturns the rate of unemployment among newly-arrived migrant groups is three times higher than that in the general population. Even for individuals who have not recently arrived, there are a number of factors which make it harder to obtain and keep jobs. These include the reduction in the number of jobs in manufacturing and construction, lack of proficiency in English required for employment in the service sectors, poor qualifications or overseas qualifications not being recognised. For migrants who have been accepted under humanitarian programs (refugees and asylum seekers), unemployment rates are particularly dire, reflecting their traumatic experiences of conflict, destruction of family networks, displacement and limited opportunities for education (FECCA 2013).

It would therefore seem likely that for many migrant children, or children of migrants, disadvantage and unemployment can persist across generations. This is reflected in a study, based on data from the 1991 and 1996 Censuses, which examined the influence of neighbourhoods and families on employment outcomes for young people. Perhaps not surprisingly, the offspring of more affluent, employed and educated households did quite well, while:

> The following variables had a negative impact on the dependent variable: presence of people with a non-English speaking background, mobility, adult unemployment and one-parent families. One of the most substantial determinants of youth employment–population ratios is the level of adult unemployment in a neighbourhood (Kelly & Lewis 2002, p 407).

More recent research has explored issues based on two surveys of culturally and linguistically diverse young people. The impact of household/parental unemployment was noted, with higher youth unemployment in some first and second generation migrant groups including those from the Middle East, North Africa and Vietnam. The authors commented that unemployment is exacerbated by the decline of unskilled employment and funding for education and skills development. On a more positive note, the majority of young respondents to the surveys possessed strong identities in regard to both their culture of origin and being Australian and did not perceive that they were living in marginalised 'ghettos'. Despite experiencing racism and discrimination in employment, they maintain aspirations and valued the support of family networks. These positive factors may build resilience and mitigate the negative psychological effects of unemployment (Jakubowicz et al 2014).

Probably the most disadvantaged ethnic/cultural groups in Australia are Indigenous peoples, especially those in remote communities. The Close the Gap initiative which commenced in 2008 acknowledged the significant gap in life expectancy between Indigenous and non-Indigenous Australians and the improvements in community health, individual health and participation that are required to improve the wellbeing and longevity of Indigenous people (Holland 2015). The most recently available ABS data show that Indigenous unemployment is approximately three times higher than for the general population and is highest in remote areas (ABS 2012).

The complexities of Indigenous disadvantage are beyond the scope and capacity of this research. However, it will be suggested that many of the issues of unemployment and its association with poorer mental health will be as relevant to young Indigenous Australians as to the remainder of the population.

Evolution in policy since 1990 – the introduction of the Common Youth Allowance, redefining independence and dependence

Prior to 1987, unemployed young people aged 16 and 17 were able to receive benefits in their own right, albeit at a rate much lower than that paid to over 18 year olds. This minimal rate was payable regardless of family circumstances. A higher Young

Homeless Allowance (YHA) was introduced in 1986, for 15-17 year olds who could not live at home due to family breakdown or circumstances such as domestic violence. An equivalent rate of payment was available to students in similar circumstances, through the AUSTUDY student assistance system.

Progressive changes since 1987 have introduced more restrictions on payments for younger people, based on age and family income and assets. Youth Allowance was introduced in 1998, replacing other payments for unemployed people under 21 years and full-time students under 25. People in these two groups were only considered independent from parental means tests if they were unable to live at home (strict eligibility similar to the YHA), or had established independence due to substantial periods of full-time or part-time work (Ey 2012).

These policies appear inconsistent with all other legal definitions which accept that adulthood commences at 18 years of age. Recent Commonwealth budget proposals for welfare reform have included further restrictions on payments to people up to the age of 30 years (DSS 2014; 2015). These proposals will be discussed later in this section.

Disability Support Pension data and policy relevant to under 25 year olds

The Disability Support Pension was introduced in 1991, replacing the Invalid Pension which was originally established by the Commonwealth government in 1910. A significant change in policy was that the DSP was based on the rating of a person's impairment for full-time work, allowing recipients to work up to 15 hours per week. Eligibility for the Invalid Pension had been based on 85% 'permanent incapacity' for work (Herscovitch & Stanton 2008).

The number of people receiving DSP rose sharply over the following two decades, from 334,234 in 1991 to 792,581 in 2011. In 2015 the number of recipients is estimated at more than 820,000 (DSS 2014; 2015). However, this apparently alarming growth in numbers reflects a relatively minor increase in the number of pensioners as a proportion of the working age population, and this proportion has actually fallen since 2010 (Jericho 2014). The increase in older people and women receiving DSP has

also been attributed to changes to eligibility for other income support payments, for example the abolition of Widow Pension and the higher qualifying age for Age Pension (McVicar & Wilkins 2013).

For the purposes of this research, it is important to note some of the characteristics of this group. Most DSP recipients are older: 56.2% are over the age of 50, in comparison to only 5.6% under 25. About one third of current DSP recipients have a psychiatric or psychological condition as the primary diagnosis for pension eligibility. For the 55,092 DSP new claims granted in 2012-13, 17,348 (31.5%) were for this primary diagnosis.

Of all new claimants under 25 (8,217), 3,175 or 38.6% were granted DSP for psychological or psychiatric conditions (DSS 2013). It can be seen that the proportion of younger people granted DSP is low. It would be expected that young people would experience fewer serious and chronic physical illnesses and therefore, for those granted DSP, there is a relatively higher percentage with mental illnesses.

In 2012, eligibility criteria for DSP were changed, with amended 'impairment tables' specifying how physical, mental and functional conditions should be assessed in relation to work capacity. In regard to a claim on mental health grounds, an applicant will need to establish that he or she has received treatment and the condition would need to be unchanged or not improved over a 12 month period. Furthermore, the applicant would need to demonstrate that the mental health disorder, whether continuous or episodic, has a significant impact on his or her ability to manage normal activities including obtaining or maintaining employment (DSS 2012).

It therefore appears unlikely that young people experiencing the high prevalence disorders of anxiety and depression, up to one in four of the population aged over 16 and under 25 years, will be receiving the DSP unless they are severely unwell. In 2013, there were 2,823,447 Australians in this cohort, with only 16,337 receiving DSP on the grounds of a psychological or psychiatric diagnosis – fewer than one in 170 (ABS 2013, DSS 2013).

Current proposals for 'welfare reform'

As has been discussed in this chapter, unemployment and underemployment affects a sizeable number of younger Australians, albeit to a lesser degree than in many other developed nations. The incidence of youth unemployment is very high in some metropolitan and rural regions where there are limited job opportunities.

In spite of the evidence of persistent high rates of unemployment, younger unemployed Australians have been targeted by proposals to further restrict access to income support. In the 2014 Federal Budget, significant changes were proposed which would affect unemployed people under 30 years old. There would be a waiting period of up to six months before Youth and Newstart Allowances could be paid. Eligibility for payments would be restricted to six months in any 12-month period and qualification for payments conditional on participation in a reintroduced 'Work for the Dole' program. People aged 22 to 24 years would receive the lower and more restricted Youth Allowance instead of NSA (DSS 2014).

The 2014 Budget changes were not passed by the Parliament. The May 2015 Budget proposed a modified version of the policy, which would retain the change of age eligibility for NSA but reduce the waiting period for YA and NSA to a maximum of five weeks (DSS 2015).

Another change in the 2014 Budget which did not require changes to legislation and came into effect in July 2014 affects DSP recipients under 35 years. Those who have been assessed as capable of working more than eight hours per week are subject to compulsory 'participation' requirements, which can include job search, training and education (DSS 2014). As this is a new measure it has not been possible at this time to obtain any information about the numbers of people who have been reviewed and any improved outcomes in actual participation.

2.6.3 Unemployment and mental health

Evidence of association between unemployment and anxiety/depression, relevant international data comparative to Australia

As has been discussed, unemployment and exclusion from economic participation have been considered as part of the social determinants of health and mental health. This section will examine the range of literature covering the association between unemployment and poorer mental health.

At this point it is important to keep in mind both structural and proximal factors. For example, significant structural factors can include the labour market and geographic isolation. Proximal factors, especially for younger people, will include individual and family circumstances which contribute to poor mental health and entrenched disadvantage, for example parental poverty, domestic violence and family breakdown.

As the title of this section suggests, there is not always a clear or simple cause and effect and the complexity of the issues require careful exploration. This exploration is based on some key questions:

- What effect does unemployment have on mental health?
- How much does anxiety and depression contribute to people becoming or remaining unemployed?
- What are the negative synergies of unemployment and mental health disorders that perpetuate each other and contribute to social exclusion?

There is a large body of literature on the effects of unemployment on mental health and social wellbeing. One particularly notable study was a meta-analysis of a large number (324) of cross sectional and longitudinal studies and other meta-analyses. The study concluded that unemployment is invariably associated with psychological distress, with unemployed people experiencing distress at much higher levels than people in employment. The authors acknowledge that many other variables also affect the level of distress experienced by individuals; these include gender, socioeconomic status and duration of unemployment (Paul & Moser 2010).

A focus of many studies is the effect of large-scale job losses caused by industry closures, typically affecting older men in traditional blue-collar employment. A review conducted in the United Kingdom examined how health services might respond to individuals affected by the closure of coal mines. The review examined evidence from both the UK and other countries that consistently found higher mortality and morbidity rates among unemployed men, as well as poorer mental health outcomes for their families. The authors of the review found that these health effects occurred regardless of age, socio-economic status or pre-existing morbidity (Wilson & Walker 1993).

A more contemporary Australian study surveyed the effect of redundancy on car workers in Adelaide, following the closure of an entire factory (Jolley et al 2011). A number of participants in the study (35%) reported negative effects on personal and family life following the loss of employment; however a significant number (17%) reported positive outcomes, such as spending more time with children and grandchildren. This study also noted the important protective effect of support for finding another job, redundancy payouts and access to income support and public health services. The outcomes in the Australian context compared favourably with other studies, for example in the United States, where government support for unemployed workers is minimal and time-limited.

Analysis of the data from the 1997 National Survey of Mental Health and Wellbeing found that the prevalence of anxiety and affective disorders was significantly - approximately three times - higher in respondents who were unemployed or not in the labour force (Comino et al 2003).

The Household Income and Labour Dynamics Australia (HILDA) survey data have also been examined with similar results (Butterworth et al 2004). The authors of this study commented that causality, whether unemployment is a cause or effect of poor mental health or *vice versa*, is difficult to determine and consideration of this issue may distract from addressing personal and societal issues:

> Taking the example of unemployment, there is widespread acceptance that the experience of unemployment can cause a decline in mental health (Murphy and

> Athanasou, 1999). Nonetheless, for some people, mental illness may be the primary reason for their unemployment (i.e., selection into unemployment). What is more, the relationship between these two constructs becomes more complex and intertwined over time, with deteriorating mental health as both a consequence of unemployment and a growing barrier to efforts to end this state (Butterworth et al 2004, pp153-154)

Butterworth and his co-authors cite the Christchurch Health and Development Study (CHDS), noting that:

> It is also likely that early adverse experiences, social disadvantage (e.g., family dysfunction and instability, abuse/trauma), social isolation and loss of self-esteem, and health risk behaviours are common factors underlying later experience of both unemployment and poor mental health (Fergusson et al 1997 & 2002).

The 1999 study by Murphy and Athanasou, cited by Butterworth et al, is significant in that it examines sixteen longitudinal studies conducted in Australia, European countries and the United States. Some studies particularly focussed on young people and many used the General Health Questionnaire (GHQ) to assess participants' physical and psychological well-being. The unambiguous conclusion was that unemployment and loss of employment has negative effects for people's mental health. The study found some data that showed improvements in mental health when people moved back into employment, but noted that there was limited research in this area.

A more contemporary longitudinal study conducted in Sweden over a period of more than 25 years has demonstrated that the experience of unemployment when young has very long-term effects, with:

> …an accumulation in poorer mental health among respondents with unemployment experiences during two, and even more so three, of the periods…There are long-term mental health scarring effects of exposure to youth unemployment and multiple exposure to unemployment during the life course (Strandh et al 2014, p440).

Writing in the ACOSS quarterly journal *Impact*, Peter Butterworth summarised his research over many years which has examined the association between receipt of welfare payments and mental health. The article expressed particular concern about younger Australians and the high prevalence of common mental health disorders:

> …the burden of mental disability falls mainly upon the young. As a result, the onset and impact of common mental disorders co-occurs with significant life stages including the transition from adolescence to adulthood, impacting on education and early labour-force experiences, family formation, child-rearing and career development (Butterworth 2008, p16).

Butterworth argued that welfare reform focussing on a 'work-first' approach may be over simplifying the effects of welfare dependency as a singular cause of mental distress. In earlier research conducted about the wellbeing of lone mothers a number of negative life events were identified, such as poverty, abuse in childhood and family violence. These were considered to be significant adverse factors causing both poor mental health and longer periods of reliance in income support (Butterworth 2003).

Butterworth co-authored a report commissioned by the Commonwealth Government which specifically examined how mental health problems might be addressed to promote employment (Butterworth & Berry 2004). This report acknowledges a large body of evidence about the negative effects of prolonged unemployment. More significantly it focussed on the effects of common mental health problems on people who are unemployed, as well as those in work. A number of approaches and possible interventions were outlined; these will be considered and discussed in more detail in the following chapter.

A more recent Australian systematic review covered similar ground, with particular regard to the impact of common mental health disorders on employment and unemployment (Harvey et al 2012). The review also examined the negative effects that some types of work, or workplaces, can have on mental wellbeing. It also explored how work can promote wellbeing and some of the issues raised will be considered in the following chapter.

It can be seen that the factors of adversity and disadvantage described by Butterworth strongly aligns with the social determinants of health, as previously discussed. Multiple and sometimes complex factors need to be considered, not merely whether a person is employed or is experiencing mental distress. It is important to acknowledge the influence of social factors and these have been examined in a systematic review of international studies. The authors concluded that:

> Common mental disorders are significantly more frequent in socially disadvantaged populations. More precise indicators of education, employment and material circumstances are better markers of increased rates than occupational social class (Fryers et al 2003, p229).

Other factors: mental health and substance use

In the introduction to this research I noted my observations from practice that many of the young unemployed people I interviewed had experienced multiple adversities and had starting using drugs and/or alcohol in their early teens. Cannabis was by far the most popular substance of choice and many individuals disclosed that they used it daily and frequently.

My hypothesis at that time was that this pattern of use (dependence) was a form of self-medication; many clients agreed that they had moved quickly from occasional recreational use and were smoking cannabis as part of coping with stress and anxiety. Unfortunately these habits and the effects of daily usage appeared to have negative outcomes in regard to general health and wellbeing, motivation and meeting the activity requirements of income support payments. Although this may well be anecdotal, I recall job services providers saying that regular drug users would exclude themselves from ever applying for industrial or construction jobs where drug testing would be part of the selection process.

The comorbidity of mental health and substance use disorders is widely recognised (AIHW 2014). Australians are enthusiastic consumers of cannabis, it is the most popular illicit drug, with lifetime and regular usage rates among the highest in the world (Degenhardt & Hall 2012).

The associations between comorbid disorders and unemployment could form a major research topic in themselves; while this is not the main focus of the current research a brief exploration of the literature has been undertaken. This will be relevant to discussions and recommendations about how policy and services can be improved to assist younger people into economic and social participation.

Australian governments have developed the National Drug Strategy, originally introduced in 1985 as the National Campaign Against Drug Abuse. The strategy has

incorporated a number of national surveys of usage of alcohol, tobacco and illicit drugs, as well as misuse of pharmaceuticals. The most recent survey conducted in 2013 identified SDH factors associated with higher levels of alcohol and drug use and identified a number of population groups who are most at risk from harmful usage. One such group is unemployed people:

> Use of illicit drugs in the past 12 months was more prevalent among the unemployed, with people who were unemployed being 1.6 times more likely to use cannabis, 2.4 times more likely to use meth/amphetamines and 1.8 times more likely to use ecstasy than employed people.
>
> The declines (daily smoking, risky drinking, recent ecstasy use) and rises (pharmaceutical misuse) that were seen nationally were also seen among employed people but there were no significant changes in the drug-taking behaviours of unemployed people and people who were unable to work between 2010 and 2013 (AIHW 2014, p84).

My practice experiences and recollections are by their very nature unsystematic. They are nevertheless validated by a recent Australian study examining the characteristics of a cohort of 696 young people seeking mental health assistance through *headspace* centres (O'Dea et al 2014). The study found that nearly one third of the group (29%) was assessed as 'at risk' of cannabis use. One in five of the total (19%) was classified as not in education, employment or training (NEET). In regard to this sub-group the study noted that:

> NEETs were also more likely to have a history of criminal charges and risky cannabis use (but not alcohol or tobacco) than non-NEETs (O'Dea et al 2014, p4).

Data from the Christchurch longitudinal study (CHDS) found similar associations between the early onset of cannabis use (before age 16), other problems experienced during adolescence and that there may be:

> …a causal chain relationship in which early onset cannabis use sets in train a series of social processes including negative peer affiliations, reduced parental supervision and contact and early school leaving, all of which increase the likelihood of subsequent substance use, offending and unemployment (Fergusson & Horwood 1997, p293).

A recent Swiss study of younger NEET men is much more forthright on the subject of the ill-effects of cannabis. The relevant comparisons for Australia are similar levels of

affluence/personal wealth and liberal laws on personal possession of cannabis; Switzerland however has a high level of participation by young people in employment and education with a youth unemployment rate of 7.7% (OECD 2014). The study commented that while NEET status in Switzerland is usually transient, some young men remained socially and economically disengaged and:

> …causal paths presented NEET status as a consequence of mental health and substance use rather than a cause. Additionally, this study confirmed that cannabis use and daily smoking are public health problems with adverse consequences, and thus prevention programs need to focus on these vulnerable youth to avoid them being disengaged and excluded in addition to their mental health and/or substance use (Baggio et al 2014, p243).

This Swiss study appears unequivocal in its assessment of cause and effect. An Australian review of the evidence of the link between cannabis use and mental health disorder is less conclusive, nevertheless it noted that:

> Frequent (greater than weekly) and early cannabis use is associated with risk for later dependence and a variety of other adverse outcomes such as poor school performance, early school leaving, unemployment and the use of other illicit drugs. A number of studies have found that the risk of psychosis and other adverse mental health outcomes is most marked for those who begin using cannabis at an early age. The dose-response relationship found in many studies highlights the importance of reducing the frequency of cannabis use among adolescents (MHCA - Mental Health Council of Australia – 2006, p40).

As has been stated earlier in this section, the issues of mental health and substance use comorbidity are not the primary focus of this research. This small selection of literature nevertheless demonstrates the importance of considering substance use within the broader assessment of young people's mental health and their ability to effectively participate in employment or education.

2.6.4 Policy and services

Developments in primary mental health care since 1990

Historically, mental health matters in Australia were the province of state and territory governments, with the primary focus of legislation concerned with the treatment and confinement of people with serious mental illness. The models of care were largely hospital based with community based services only evolving in the 1970s.

The first National Mental Health Policy was established in 1992 by the conference of all Australian Health Ministers. The policy identified a number of new approaches to dealing with mental health and mental illness, including the need for promotion of mental health, prevention of illness and the role of GPs and other health professionals in providing care and treatment outside of hospital (Whiteford et al 1993).

Successive iterations of policy and national mental health plans and strategies have resulted in an increased role for the Commonwealth Government in resourcing primary mental health care services. A major initiative which commenced in 2002 is Better Outcomes in Mental Health Care which:

> …recognises the central role of primary care, promotes integrated medical and psychological care, rewards treatments that occur over an episode of illness, promotes active purchasing of non-pharmacological interventions earlier in the course of illness, and attempts to better link general practitioners, nonmedical mental health specialists and psychiatrists to meet population-based mental health needs. Central to its development has been a commitment by general practitioners to develop progressively better mental health skills and measure both individual consumer and system-related outcomes (Hickie & Groom 2002, p376).

The services provided by GPs with specialist mental health training were augmented by individual and group therapeutic sessions provided by allied health professionals employed by the (then) national network of Divisions of General Practice. This program is known as Access to Allied Psychological Services (ATAPS) and successive evaluations have demonstrated that most service users have improved mental health outcomes (Morley et al 2007; Pirkis et al 2011). Outcomes for some groups have varied, for example ATAPS usage by migrants of non-English speaking background has

been constrained by limited numbers of bilingual health professionals and access to interpreter services (Klimidis et al 2006).

A subsequent national primary mental health care initiative, Better Access to Mental Health Care, was introduced in 2007 (it can be seen that the similarities in the program titles could lead to some confusion among service providers and consumers). The notable feature of Better Access included the availability of Medicare benefits for services provided by allied health professionals and by any GP, not just those with mental health training. Another notable feature of the initiative is the overall cost, which has been much greater than originally forecast in spite of a number of changes restricting the level of rebates and occasions of service to individuals (Russell 2011). The most recent statistics on MBS mental health services, including GPs, show a total expenditure of $851 million for Financial Year 2011-2012 (AIHW 2014).

Better Access is significantly different from ATAPS in regard to potential costs borne by consumers – the practitioners' receive a rebate of 85% of the 'scheduled fee' set by Medicare but can charge a gap or co-payment in addition to this. In comparison, ATAPS services are either completely free or have a nominal small charge at the discretion of the provider (Senate Community Affairs References Committee 2011).

Another important issue is that of access to services. Quite apart from cost barriers, access is frequently determined by the location of private practitioners. More are located in more affluent metropolitan areas compared to poorer outer suburbs and rural regions. This is confirmed by large regional variances in use of Medicare GP and allied health services and what some researchers have termed the "failure of the Medicare principle of universality" (Meadows et al 2015).

Despite some limitations of these initiatives as discussed, there is consensus that many hundreds of thousands of Australians have been able to receive assistance with their mental health disorders, where previously there were limited options (AIHW 2014). This is reflected in the majority report of the 2011 Senate Committee. This

Committee also noted the Department of Health and Ageing review of ATAPS which indicated a need to improve services to some groups:

> Key groups within the community such as children and youth and Aboriginal and Torres Strait Islander people, remain a significant priority and require care sensitive to their needs and which they are more likely to access (DoHA 2010, p7).

A third initiative in primary mental health care, specifically for young people (aged 12 to 25) is *headspace*. The *headspace* organisation is a not for profit corporation established in 2006 with Commonwealth funding. There are currently more than 60 centres across Australia with a total of 100 expected to be in place by 2016 (Rickwood et al 2014). The centres provide a range of clinical services and other activities, services are funded via an arrangement similar to ATAPS, with some practitioners claiming rebates through Better Access.

As with Better Access, there are geographic inequities in availability of services. Taking two States as an example, there are six centres in South Australia. Three cover the more disadvantaged regions of Adelaide (Outer North, Outer South and North West); the others are at Port Augusta, Murray Bridge and Berri. The major regional centres of Mount Gambier and Whyalla are not serviced, nor are regions with significant populations such as the Mid North. Victoria would appear to have a similar situation, with 12 centres in the greater Melbourne area, another seven in major regional cities, but no services in the rural eastern and western parts of the State.

The *headspace* model has attracted some criticism in regard to the lack of universality and its cost and effectiveness (Hickie 2015). These issues will be further explored and discussed in the next chapter.

Data identifying young peoples' use of mental health services

As previously discussed in this chapter, the 2007 National Survey of Mental Health and Well Being identified the high prevalence and onset of mental disorders in the Australian population aged under 25 years. The higher proportion of GP mental health

services (Mental Health Treatment Plans) used by younger people has also been noted. The GPMHP data for 2012-2013, with 163,912 plans completed for people aged 15-24, is a useful indicative figure of service use, as the completion of a plan is a prerequisite for referral to ATAPS, Better Access and some (but not all) *headspace* services (Department of Human Services 2014). This figure is also a reliable indicator of the overall number of young people seeking help in the given year, as only one GP plan, or review of an existing plan, can be conducted in a 12-month period.

Medicare Benefits Schedule (MBS) data are available for other services provided by GPs, psychiatrists and other allied health professionals. However, while providing a breakdown of services by state or territory and by age group, they describe the quantum of recurrent services/consultations by MBS item number, and therefore cannot be used to estimate the numbers of individuals using services in a given time period.

Usage of *headspace* services has recently been collated, indicating that in one 12-month period a total of 33,038 young people commenced an 'episode of care' across the national network of centres (Rickwood et al 2015). As noted in the previous section, *headspace* services cover only part of the overall youth population so these data are only relevant to the areas where centres exist.

Mental health services for young people are also provided by state and territory governments and NGOs. The Australian Institute of Health and Welfare has noted that:

> State and territory governments have also been developing and augmenting existing youth services; for example, Western Australia recently established Statewide Specialist Aboriginal Mental Health Services to provide specialist interventions to help in the transition from adolescence to adulthood (AIHW 2014, p135).

Some data were obtained on the usage of the Child and Adolescent Mental Health Service (CAMHS) in South Australia. The most recent statistics show that 1.9% of the population aged 15-19 years were referred to CAMHS in 2010; a high proportion of these referrals were occasioned by more acute mental health episodes including hospital admissions. A high proportion of individuals referred were Indigenous, state

wards and from more adverse backgrounds (WCHN 2010). The proportion of this population is similar to the proportion of the general population identified as experiencing more severe mental health disorders. This suggests that there is unlikely to be much overlap with the population of consumers using primary mental health care services.

The evidence from the 2007 survey of National Mental Health and Well Being is that the prevalence of mental health disorders in the population aged 16-24 years is approximately 26%, which represents slightly more than 800,000 individuals based on current population estimates (ABS 2014). Combining the MBS and *headspace* data and an estimate of up to 2% usage of acute services, it would seem that fewer than one in four younger Australians with mental health disorders are accessing clinical services. This being said, the Australian Institute of Health and Welfare have noted some improvements over the past few years:

> More recent analysis of administrative data (DoHA 2013; Whiteford et al. 2014) suggests that there has been significant improvement on the relatively low treatment rates observed in the 2007 National Survey of Mental Health and Wellbeing. The analysis suggests that the percentage of the population with a current mental illness who received care in 2009–10 was 46%, substantially higher than the 35% estimate found by the ABS in 2007. Growth in the proportion of the population seen by Medicare-funded mental health services is the sole driver of the change over the 3 years, primarily arising from initiatives introduced in 2006 to provide Medicare-funded access to mental health care by allied health professionals (AIHW 2014, p136).

Discussion and commentary on the medical vs. social construction of mental health

The introduction to this review has identified and discussed the social determinants of health and mental health, and the contention that many manifestations of mental distress and ill health have their origins in people's personal and social circumstances. The literature is also conclusive about the negative effects of unemployment on mental health and wellbeing.

The issues of cause and effect are unlikely to be agreed or settled any time soon, a current example being the controversy generated by the latest version of the

Diagnostic and Statistical Manual of Mental Disorders (DSM-5) produced by the American Psychiatric Association in 2013. As one critic has noted (himself a former psychiatrist), the range of behaviours classified as disorders continues to expand, with a resultant:

> …tendency of psychiatric diagnosis to colonize human experience (Daniels 2013).

This research is not attempting to resolve the questions of causality. However, I will be proposing that if it is accepted that adversity factors such as unemployment, poverty and comorbidity contribute to mental ill health, effective remedies should not be solely the province of medical and allied health practitioners. The evidence for Australia nevertheless suggests a tendency towards medical responses, as is demonstrated by the growth in Medicare-funded services.

Other data that would appear to support the trend towards medical models of treatment are the usage of medication in Australia. Among the 23 countries in the Organisation for Economic Cooperation and Development (OECD), Australian use of antidepressants (89 of every 1,000 people) is second only to that in Finland (OECD 2013). In addition to more than 21 million prescriptions for antidepressants, there are more than 6.5 million prescriptions supplied each year for tranquillisers and sedatives (AIHW 2013). It is worth noting, in the context of comorbidity, that the National Drug Strategy Household Survey has measured increasing misuse (non-medical use) of tranquillisers and sleeping pills by nearly 1.5% of the population. This is approximately three times the number of people who reported using heroin in a 12-month period (NCETA -National Centre for Education and Training on Addiction – 2015).

A recent Australian study confirmed a steady rise in the use of psychotropic medicines from 2000 to 2011, an increase of 58.2% over this period. The authors noted that antidepressant usage increased by 95.3%, despite evidence that these drugs can have many undesirable side effects and may be of limited efficacy in treating moderate to mild depression. The study commented that a factor contributing to the increased use

of antidepressants is the influence of the pharmaceutical industry and the subsequent prescribing practices of GPs and psychiatrists (Stephenson et al 2013).

The considerable resources devoted to psychological and pharmacological therapies may be of limited benefit. A series of population surveys conducted over a 16 year period between 1995 and 2011 concluded that there had been no overall improvement in adult mental health in Australia, despite the increased availability of services and medication (Jorm & Reavley 2012).

A factor that may explain this is how the components of distress may, or may not, be constructed as mental health disorders. This is illustrated to some extent by a survey of young people using *headspace* services in 2013 and 2014. Nearly 20% presented with concerns about physical or sexual health or 'situational' problems; the remainder had either mental health or 'behaviour' issues (Rickwood et al 2015). Even in regard to the larger group, the 'behavioural' problems would seem to encompass a rather broad range of issues.

Earlier research based on data from the 1997 NSMHWB and the 2001 National Health Survey investigated the extent to which depression can be predicted and 'indexed' at the population level. It is perhaps unsurprising that in looking at population subgroups the authors found that unemployed people and those in the five lower income deciles were far more likely to report symptoms of depression, regardless of any diagnosis or treatment (Mackinnon et al 2004).

This evidence would seem to confirm some limitations of medical models to explain and treat depression and anxiety. It perhaps also explains why many people who experience distress and disorders do not seek medical remedies, as noted by the Australian Institute of Health and Welfare, citing Slade et al 2009:

> Eighty-six per cent of those with a mental disorder who did not receive mental health care reported that they perceived having no need for any of a range of services, including counselling, medication and information (AIHW 2014, p135).

2.6.5 Summary

The literature surveyed and reviewed has highlighted the large amount of data about the prevalence of anxiety and depression and use of health services and medication. The relatively recent literature focussing on the social determinants of mental health provides a framework that clearly links mental ill health to other adversities. This in turn appears to have generated research and discussion on the underlying causes of distress with, for example, attention being paid to comorbid alcohol and drug use.

Information about the extent of unemployment is readily available from national surveys; these data indicate the extent of underemployment and unemployment affecting younger Australians as well as locations of high unemployment and associated disadvantage. The data on income support are reliable in regard to young people receiving Youth and Newstart Allowance or Disability Support Pension. However, given the various eligibility restrictions on these payments, it has been difficult to establish the number of young people with mental health disorders who may be precluded from receiving financial and other support, including access to affordable health care and medicines.

The literature review has also identified an area of concern in regard to how mental health and mental health disorders are measured and considered. There are good data on the prevalence of anxiety and depression, at least to the extent to which individuals report on the level of distress they experience. However, some of the discourse about mental health tends to conflate every disorder and malady under the broad category of illness, without differentiation of severity or causality:

> Debates among professionals about the meaning of prevalence figures and the extent of unmet need are a healthy thing. However, when the debate crosses into the public domain, we would argue that those advocating for increased funding for services and research should clearly define what they mean by the terms ‘mental illness’ and ‘unmet need’ or else refer to specific disorders. Few would argue that the level of unmet need for treatment for those with severe disorders remains an issue of considerable significance without the need for using figures that risk a credibility gap in the eyes of the public (Jorm & Reavley 2012, p 398).

One of the most significant issues identified in this review is the lack of studies examining in detail the effects of anxiety and depression experienced by young people on their capacity to participate in employment or education. There is also a deficit in research about the effects of anxiety and depression on longer term employment or unemployment, with the exceptions of the Christchurch study (CHDS) and the work by Strandh et al (2014).

Another issue identified concerns the nature of the data about the cohort of younger Australians experiencing mental health disorders and unemployment. The various survey data are 'top down' and consider statistics such as prevalence of disorders and percentages of unemployment. There appears to be very little work being done on examining the quantitative data and considering these within the context of the lived and living reality of a significant number of young people. This compares unfavourably with work that has been done about people experiencing more severe mental illness, such as the comprehensive report of the National Mental Health Survey which investigated the health, personal and social circumstances of Australians living with psychosis (Morgan et al 2011).

It has also not been possible to establish accurately the dimensions of the population and their associated problems. The literature clearly shows that in Australia and many other developed countries young people are more likely to be unemployed and experience mental health disorders, comorbidity and precarious financial security. It is nevertheless difficult to arrive at even a rough estimate of how many young Australians are experiencing the overlapping of these multiple adversities.

Given the complexities of the research question and the limitations of data, my research will not be attempting to quantify all aspects of the problems of unemployment, ill health and exclusion. What this review of existing data does demonstrate is the need to further investigate issues for younger Australians, including the gaps in knowledge and why these gaps exist.

The research methodology and methods outlined in the next chapter will attempt to address the issues identified in a new way. In summary, there are sufficient, if patchy,

data from various sources which indicate the disadvantages experienced by young unemployed people. Among the questions my research will attempt to answer is how the development of policy and services does not give sufficient attention to the complexity of mental health and unemployment and the actual circumstances of an important group of citizens and their present and future full participation in society.

A key aspect of the research is therefore how young people are represented as the 'problem', rather than a more nuanced examination of young people and the problems that they experience in navigating their course through life. This will be discussed in more detail in Chapter Four.

The conclusion to this research will explore gaps in knowledge and research identified in the literature, what needs to change to improve participation outcomes for young people, what could be achieved if existing resources and services were better integrated, what models of integrated service provision exist and how these could be applied and adapted to the various needs of individual young people.

3. THEORY, RESEARCH METHODOLOGY AND METHODS

3.1 The theoretical framework

As outlined in the introductory chapter, the research has been undertaken as a secondary analysis of data about, and policies affecting, younger Australians. The literature demonstrates that this research requires interpretation from a sociological perspective – understanding the circumstances of the target population within the social context.

To paraphrase the sociologist C. Wright Mills, the circumstances facing young people with anxiety and depression can be characterised as individual *troubles*, with the broader *issues* being unemployment and disadvantage. Even though Mills was writing more than 50 years ago, during what in retrospect may be seen as a 'golden age' of economic growth and full employment, he was unambiguously critical about societies' failure to acknowledge and address issues arising from unemployment:

> When, in a city of 100,000, only one man [sic] is unemployed, that is his personal trouble, and for its relief we properly look to the character of the man, his skills, and his immediate opportunities. But when in a nation of 50 million employees, 15 million men are unemployed, that is an issue, and we may not hope to find its solution within the range of opportunities open to any one individual. The very structure of opportunities has collapsed. Both the correct statement of the problem and the range of possible solutions require us to consider the economic and political institutions of the society, and not merely the personal situation and character of a scatter of individuals (Mills 1959, p15).

I suggest the above statement would seem reasonable and sensible to most people, however in the contemporary political climate the broader social and economic factors are at times downplayed or disregarded.

The literature review has elucidated empirical data about the research topic and the population. I initially considered basing the research methodology on a positivist approach, based on quantitative data about the population. However, while there are considerable data about unemployment and prevalence of mental health disorders, these data do not in themselves tell a great deal about the population of younger Australians and their individual experiences. Furthermore, the data show that the

population is far from homogenous, for example rates of unemployment are determined by variables such as location, social class, ethnicity and health.

The theoretical perspective for this research therefore needs to consider the experience of individuals and groups in relation to their social and economic environments, and in particular to their relationship with government and other agencies.

In the previous chapter reference was made to Michel Foucault and his argument that 'madness' is socially defined, and people are labelled as such because they do not behave as they are supposed to. A number of other elements of Foucault's work will provide a theoretical framework or 'lens' for this research.

In *The Archaeology of Knowledge* (1979) Foucault examined historical developments in society and some of its institutions, such as medicine, psychiatry and prisons. He employed the theory of discourse to describe how various factors and events can be understood in regard to their relationships with each other and within the context of the broader culture, language, rules and norms. An important feature in such critical analysis is to consider carefully the extent to which the context is taken as read (for example, that there is a general consensus about the necessity for and the nature of social provision by government):

> In any case, these divisions – whether our own, or those contemporary with the discourse under examination – are always themselves reflexive categories, principles of classification, normative rules, institutionalized types: they, in turn, are facts of discourse that deserve to be analysed beside others; of course, they also have complex relations with each other, but they are not intrinsic, autochthonous, and universally recognizable characteristics (Foucault 1979, p25).

The literature suggests that developments in policy and service provision for young Australians have occurred in a piecemeal and haphazard fashion. A succession of policies has emanated from different governments and authorities, often in response to a particular perceived problem or with little regard to what has been tried before and found to be useful (or not). As I have noted elsewhere, the Australian income support system has continued to redefine 'youth' by progressively raising the age at

which independence is achieved. There is also an apparent need for a greater degree of coercion to ensure young people 'earn or learn'. The scope of the research question therefore requires careful scrutiny of the rhetoric and language applied to young people:

> The question posed by language analysis of some discursive fact or other is always: according to what rules has a particular statement been made, and consequently according to what rules could other similar statements be made? The description of the events of discourse poses a quite different question: how is it that one particular statement appeared rather than another? (Foucault 1979, p30).

Just as the construct of madness can be questioned, so can the portrayal or understanding of anxiety and depression. The data on the usage of medication would suggest that biochemical approaches to treatment are strongly favoured in Australia, regardless of the personal and social factors that contribute to depression. Similarly other therapies, in particular cognitive behavioural therapy (CBT) are prescribed as preferred 'evidence-based' treatments (Australian Psychological Society 2007).

As the literature has described, various policies and payments for younger people have developed over time, more recently to control or restrict access to unemployment and disability payments or to impose strict conditions on activities such as job-seeking. This represents what Foucault described as 'governmentality' – the increased regulation of citizens by government and the increased requirement for citizens to regulate themselves to comply with the rules for receiving income support (McDonald & Marston 2006).

Foucault also identified the increased tendency of state agencies to practice 'descending individualism', where the lower a person is in the social hierarchy, the more likely it is that he or she will be subject to surveillance and monitoring (Danaher et al 2000). Although nowadays we are all subject to monitoring, for example in regard to our internet usage and 'data mining' of our purchases, people receiving income support have for many years been required to report regularly on their personal and financial circumstances. Income management is being applied to

increasing numbers of citizens, whose fortnightly payments are stored on a bank card which can only be used to purchase specified goods.

3.2 Methodology - addressing the problem and its representation

Foucault observed that institutions require individuals to conduct themselves in particular ways, thereby establishing norms and normative behaviours (Oliver 2010). This in turn identifies people and behaviours which do not conform to what is required or expected. Social structures also use particular language, or 'discourse' to define their values and expectations.

This research will analyse the discourse within social and health provision, in particular how the language and terminology of policy and institutions compares to the efficacy of what they actually provide. As a preliminary observation of the power of language to shape discussion, we can note that the term 'social security' has generally been replaced by 'welfare'. The former suggests citizens' entitlement to secure and reliable income support, the latter discretionary entitlements which can be more easily withdrawn if individuals fail to comply with the various conditions and obligations attached to payments.

The literature review has identified the social determinants of health (SDH) as a useful means of beginning to understand the associations between unemployment and common mental health disorders. The development and evolution of SDH can be seen as a discursive process which has increasingly taken into account the social, economic and environmental factors which affect the health of individuals and communities.

The critical analysis of problems and policy uses the framework developed by Carol Bacchi and detailed in her book *Analysing Policy: what's the problem represented to be?* (Bacchi 2009). The question, "what's the problem represented to be (WPR)", challenges the notion that the development of government policy is a logical, rational and iterative process that exists to 'fix things up'.

The WPR approach is an exploration of the process of making public policy, including policy responses to difficult or 'wicked' problems. It is argued that much government policy involves the development of programs in response to identified problems, although these problems are often implied and not necessarily defined in detail – for example 'welfare dependency'. It is suggested that the definition of problems reflects deep-seated cultural assumptions, and that these in fact define the problem within a predetermined view and framework, e.g. 'work is the best form of welfare'.

WPR suggests that government policies are therefore defined by 'problematisation', what we, or our governments, think needs to be fixed. The implied problem is therefore a version - *a problem representation.*

The WPR framework sets six questions as a basis for policy analysis:

1. What's the 'problem' (e.g. of 'problem gamblers', 'drug use/abuse', 'domestic violence', 'global warming', 'health inequalities', 'terrorism', etc.) represented to be in a specific policy?
2. What presuppositions or assumptions underlie this representation of the 'problem'?
3. How has this representation of the 'problem' come about?
4. What is left unproblematic in the problem representation? Where are the silences? Can the 'problem' be thought about differently?
5. What effects are produced by this representation of the 'problem'?
6. How/where has this representation of the 'problem' been produced, disseminated and defended? How could it be questioned, disrupted and replaced?

Bacchi provides numerous examples of how contemporary social issues in Australia can be examined using the WPR approach and the book includes chapters on welfare, youth and unemployment and the social determinants of health.

The WPR approach draws on the work of Foucault, incorporating discourse analysis and describing the use of political/governmental power in shaping the language and premises of policy. Problems can be and are represented as mutually exclusive 'binaries', for example a citizen can be considered as employed or unemployed, independent or dependent and behaviour as licit or illicit.

This portrayal of problems, individuals or groups also represents what Foucault described as dividing practices. As has been noted, current policies divide younger Australians from other cohorts and they are treated differently in regard to access to income support and other social benefits.

3.3 Methods – selecting policies for consideration

The literature shows that over recent decades a number of policies have evolved which affect younger Australians. The key legislation in regard to income support is the Social Security Act. The legislation is administered by the Department of Human Services via the Centrelink agency. It has therefore been necessary to look at policy on a number of levels, including the legislation, administration guidelines and how people are categorised in regard to eligibility for different types of payments. These policies also affect the operations of nongovernment agencies such as those providing employment services, which are contracted to manage young people's compliance with job seeking and participation.

Mental health policies are also complex and at a high level represent the collective aspirations of all Australian Governments: the successive National Mental Health Plans and Strategies. In practice, policies are administered by three Commonwealth Government Agencies – the Departments of Social Services, Health and Human Services. The detail of these policies is usually found in departmental guidelines, for example program funding agreements and the Medicare Benefits Schedule.

Another 'aspirational' policy is the National Drug Strategy which has been developed by Commonwealth, State and Territory Ministers (NDS 2011). This policy was examined because it recognises the comorbidity of mental health disorders and drug and alcohol use.

Data, evaluations and reports have been sourced from other organisations, such as the Australian Institute of Health and Welfare. These documents provide additional

detail about the population group and policies such as income support and access to health services.

It is notable that there is not a national policy or strategy concerning youth unemployment. This gap will be discussed in the following chapters. It can be concluded that at present there is a disparate set of policies that apply to younger Australians, with responsibilities for delivery of services occurring across a range of agencies. In regard to young people experiencing difficulties with participation and mental health, I considered the concept of the 'wicked problem' as providing a good starting point for framing the issues. As described by Rittel and Webber, a wicked problem is a social issue which can be difficult to clearly define, results from multiple causes and is not easily solved (Rittel & Webber 1973).

This reflected the complexities of what I had already observed and experienced in social work practice and my preliminary attempts to make sense of the many issues affecting unemployed young people. Aspects of the wicked problem pertaining to the research will be discussed in detail in the next chapter as they provide a useful template for describing interrelated causes and effects.

I will note at this point some limitations of this construct. While by definition a wicked problem may not have a ready solution, this does not mean that there should not be attempts to address aspects of the problem. The (hopefully achievable) purpose of this research is to scope ideas for improvement and possible further research into what could be done to improve opportunities and the wellbeing of younger Australians.

This research has also considered a wide range of academic research and commentary relevant to the topic. In Australia we fortunately have a number of institutions, such as the Australian Institute of Health and Welfare (AIHW) and the Social Policy Research Centre (affiliated with the University of NSW), which undertake high quality research. In addition, academic work in diverse fields including social work, economics and public health has provided a rich source of evidence and commentary.

Much of this work contests the somewhat asinine discussion and development of policy by the major political parties and ‘mainstream’ media.

4. DISCUSSION AND PROBLEM ANALYSIS

4.1 Introduction – the 'unknown unknowns'

To borrow an idiom from the bombastic former US Secretary of State Donald Rumsfeld, the Literature Review has identified things that are known about unemployment and the mental health (or otherwise) of younger Australians. This chapter will explore the things we know that we don't know, for example the extent to which young people's experience of poor mental health and distress contributes to their becoming and remaining unemployed. The next chapter will then seek to address, as far as possible, the things we at present don't know that we don't know, by proposing different approaches to research and policy development.

I have noted earlier the lack of a national policy or strategy on youth unemployment. What we do have is a number of Commonwealth departments which are responsible for policy, funding and program administration in regard to mental health, employment, education and income support. In the absence of a national strategy, it appears that young marginalised Australians with mental health issues are subjected to a range of disconnected policy and service initiatives, rather than an integrated or holistic approach to improve their circumstances.

The topic of this research can be re-framed as questions: '**How** to improve social and economic participation for young people experiencing anxiety and depression?', or perhaps '**What** barriers or problems prevent the social and economic participation of young people (etc.)?' When expressed in this way, the requirement to better understand the nature of the problem(s) arises. This then leads to the need to discuss the representation of the problem – is there perhaps a wilful disregard of the circumstances of young people and a deliberate ignorance of why this matters?

4.2 Aspects of the research and the wicked problem

I have chosen the concept of the wicked problem to illustrate the main facets of the research question. The concept aligns well with the discursive nature of the formation of policy and, although it does not necessarily provide solutions it is useful in identifying some of the critical issues being examined.

Within the Australian context, the Australian Public Service Commission has described wicked problems as a common challenge for governments as they attempt to develop social, economic and environmental policies (APSC 2007). The Commission drew upon the earlier work of Rittel and Webber (1973) to develop a framework for contemporary policy makers. While primarily written for Commonwealth Government agencies, the document acknowledges the complexities of the three levels of government in Australia, regional and cultural diversity and the delivery of services by a mixture of government, nongovernment and private agencies,

The research question is examined using the Commission's definition of the elements of a wicked policy problem. The discussion in the next few pages uses the APSC template (sub-headings) to explore some of the complexities of the issues affecting young unemployed Australians.

Wicked problems are difficult to clearly define: There are several aspects to the issue of youth unemployment. The comparative data on unemployment rates between countries and between regions in Australia suggest that economic conditions are a significant contributor to high rates of youth unemployment. Other factors appear to be harder to quantify, for example how much the lack of skills, or the opportunity to obtain skills, will preclude young people from local employment opportunities.

The literature shows that prolonged unemployment is generally detrimental to a person's psychological, social and economic wellbeing. This in itself formulates a problem; however it can also be argued that individuals experience social exclusion as a result of the poverty and stigma associated with unemployment. Welfare 'dependency' is often described as a problem, but the payment of a decent level of

income support could alternatively be seen to represent a reasonable social contract that ensures citizens are not cast into abject poverty if they cannot support themselves through paid work.

Wicked problems have many interdependencies and are often multi-causal: the literature on the social determinants of health shows that disadvantage and poor mental and physical health result from a combination of factors. This has been clearly illustrated by the Christchurch Health and Development Survey, which identified adversities experienced by people in childhood continuing and compounding in adulthood. The Northern Swedish Cohort study found that people who experienced early and multiple experiences of unemployment continued to experience poorer mental health during the life course.

Evidence from the literature suggests higher prevalence of mental health disorders in unemployed populations, as well as higher rates of alcohol and illicit drug use. The data on young people who use drugs frequently, notably cannabis, indicate that they are far more likely to be unemployed. However, I would note from my practice experience that there may be something of a 'chicken and egg' phenomenon occurring here, as drug use and self-medication can also represent a coping strategy for dealing with the boredom and isolation associated with unemployment.

The causes of the high prevalence of anxiety and depression experienced by younger Australians require some consideration. The data from the literature suggest that while significant resources are allocated to clinical therapies, including medication, very little work has been done to explore the degree to which social and economic factors contribute to poor mental health. Other factors that contribute to mental health disorders might also be considered, including a culture that promotes individualism and some negative effects of social media such as 'cyberbullying'.

Attempts to address wicked problems often lead to unforeseen consequences: there remains a considerable gap between the payments for unemployed people (Youth and Newstart Allowances) and the very minimal poverty line, with access to Youth Allowance greatly restricted. The low rates of payment may be sufficient for

people who are briefly between jobs and might even be considered to provide an incentive for people to find employment quickly, but they hardly provide for the many people who remain out of work for months or years. In recent times even conservative organisations such as the Business Council of Australia have called for an increase in these allowances, suggesting that duration of unemployment can be prolonged for people who lack resources for job seeking, such as transport, clothing and communication technology (BCA 2012).

Some proponents of welfare reform point out that the higher level of Disability Support Pension (DSP) payments have encouraged people to try and obtain this rather than remain in the labour market on much lower payments (DSS 2015b). A perverse outcome of the changes to DSP eligibility and intensive reviews of younger DSP recipients may be to discourage people getting the appropriate level of support or attempting to re-enter employment or education.

Wicked problems are often not stable: the evidence from Australia and other developed countries shows that unemployment rates are highly sensitive to volatile economic circumstances. There are also longer-term changes to the labour market, for example increased casualization of jobs and the decline in local manufacturing industries.

Eligibility requirements for income support for young people have changed significantly in the past two decades. Based on announcements in the 2014 and 2015 Federal Budgets, payment appear to be destined for further restrictions (Department of Social Services 2015).

Wicked problems usually have no clear solution: in the absence of a clear national strategy to address the high rate of youth unemployment it does not seem likely that solutions will be implemented in the near future. The literature shows that even when unemployment has been historically low, a significant cohort of young people is unemployed for long periods of time. This indicates that other factors require investigation, such as individuals' capacity to obtain and maintain employment.

There do not appear to be simple solutions regarding the high prevalence of mental health problems experienced by young people. As has been discussed, the causes of an individual's ill-health may be multiple and addressing these may therefore require offering a broader range of supports and interventions.

Wicked problems are socially complex: the complexities of policy and service delivery have been outlined in Chapter 1 and the literature review. The literature on the social determinants of health and mental health illustrates the many interacting variables that affect individual well-being, notably those factors over which people can exercise little control.

Wicked problems hardly ever sit conveniently within the responsibility of any one organisation: the target population for this research is likely to be dealing with (or dealt with by) a number of agencies. The focus of most agencies is narrow, for example being only concerned with eligibility for payment or compliance with seeking work. Individual treating practitioners may also focus only on an individual's symptoms rather than on their social and economic circumstances.

Wicked problems involve changing behaviour: in the current political environment, the focus would appear to be on changing individual behaviour, for example former Social Services Minister Kevin Andrews' statement that "work is the best form of welfare" in the context of a proposed review of the NSA and DSP payments (Jabour 2014). This research will focus on the behaviour change that is required of systems and agencies.

Some wicked problems are characterised by chronic policy failure: the APSC cites the entrenched disadvantage of Indigenous Australians as an example of "decades of policy failure". The same could perhaps be said of the disadvantage and social exclusion experienced by long-term unemployed people. Youth unemployment persists at levels above 20% in many regions. At the same time Australian employers continue to employ high numbers of overseas workers on temporary visas.

4.3 Analysis using the WPR framework

As outlined in the preceding chapter, this research uses Carol Bacchi's policy analysis framework "What's the problem represented to be" (WPR). This framework provides a useful and practical approach to addressing the aspects of the wicked problem described above. It also provides the structure for critical analysis within the theoretical framework.

What's the 'problem' represented to be in a specific policy?

There are two policy areas requiring this analysis. The first is unemployment and the related obligation and income support arrangements that apply to younger Australians. The second is mental health policy, also as it applies particularly to young people.

The data show persistently high rates of youth unemployment, with very high rates in some regions. There is an absence of policy or strategies to address this issue at all three levels of government, in spite of the failure of the 'market' to provide employment opportunities. Nevertheless, the problem is represented as the perceived failure of young people in finding work.

Consider, for example, this extract from the 2014 Budget Speech by then Commonwealth Treasurer Joe Hockey:

> I say to the Australian people, to build a workforce for the future, those who can work, should work. The benefits of work go far beyond your weekly pay packet. Work gives people a sense of self, and work helps to build a sense of community. That is why young people should move into employment before they embark on a life on welfare. Australians under 30 years of age should be earning or learning. From next year, unemployed people under 25 will get Youth Allowance, not Newstart. People under 30 will wait up to six months before getting unemployment benefits, and then will have to participate in Work for the Dole, to be eligible for income support (Australian Parliament Hansard, 13 May 2014).

This statement would seem to exist in a zone quite detached from the current reality of youth unemployment. It suggests that young people will not work or study of their own volition and require coercion. As the data and literature show, there are complex causes and effects which may have very little to do with a person's talents or deficits; the statement above appears to be a case of substituting opinions for facts. The Budget Portfolio Statements describe the proposed changes as 'revenue' (savings) measures. Doubtless the thousands of young people potentially relying on charity for several months might have another description for this policy.

In regard to mental health at least, policy appears to be more sophisticated. The 2008 National Mental Health Policy resulted from agreement between the Commonwealth, State and Territory Governments, and is reflected in a coherent National Mental Health Plan (DoHA 2009).

The Plan identified four priority areas: social inclusion and recovery; prevention and early intervention; service access, coordination and continuity of care; and quality improvement and innovation. In regard to social inclusion, the importance of support for people to participate in employment and education is recognised. This appears to represent a more sophisticated approach, i.e. that effective responses to mental health disorders are not solely about clinical treatment.

The Plan also acknowledges that younger Australians have particular needs, and that early intervention, including in schools, is an important factor in prevention. The document is notable in that it avoids the problematisation of young people.

What presuppositions or assumptions underlie this representation of the 'problem'?

In describing how the WPR framework can be utilised, Bacchi uses a number of case studies concerning young people and welfare which are highly relevant to this research. A salient point is made about how 'youth' is constructed in modern developed societies:

> ...the category 'youth' functions to facilitate a wide range of governmental objectives, around policing, education, population and economic concerns.

> The category 'youth' operates in public policy as if it referred to a distinct minority group, rather than to a phase of life we all live through. At the same time, there are all sorts of inconsistencies in the way the category is deployed. In Australia in the early twenty-first century a sixteen-year-old can drive a car but cannot appear in the family court in a case over their residency, and cannot make their wishes known except through an advocate to act in their 'best interests'. An eighteen-year-old can vote, get married and stand for political office. However, under the Commonwealth Government's Youth Allowance program, that same eighteen-year-old is considered to be living at home and dependent on their parents until age twenty-five (Bacchi 2009, pp 58-59).

In exploring the issues relating to young people, Bacchi examines income support policy, the Work for the Dole program and 'welfare dependency'. The construction of the 'problem' is challenged, especially as adolescents and young adults are portrayed as problematic. This portrayal seems in sharp contrast to the current high level of interest in the health and well-being of young children and improving child protection systems. Another contrast is the different treatment of older Australians, for example the significant tax relief available to self-funded retirees and the relatively generous income and assets tests applied to people receiving Age Pension. It would be a brave commentator who would refer to these groups as 'welfare dependent'.

The assumption that people of working age (16 to 65 years old) should have work as a central focus is illustrated in the most recent iteration of the Commonwealth Government's welfare reform agenda:

> The new income support system should have a strong employment focus. It should encourage and support people to work to their capacity. The new system should be simpler, easier to access and understand, be delivered efficiently and effectively and have clear rewards for work (DSS 2015, p12).

It appears that this aspiration may soon be enacted. The 2015 Commonwealth Budget has included provisions for a pilot 'Investment Approach', based on work that has already been undertaken by the New Zealand Government:

> This Investment Approach uses actuarial valuations to identify risk factors driving long-term welfare dependency. It identifies risk factors that are responsive to early effective intervention…It would also examine the characteristics of people currently receiving welfare to understand who is most likely to have an extensive reliance on welfare over their lifetime. This allows better decisions to be made on where to focus Government investment and who

> to focus on for the greatest return on investment. In this case, groups at risk of long- term dependency and disadvantage can be identified (DSS 2015).

This research is fundamentally concerned with the social investment in young people to improve their participation and social inclusion. I cannot help but think that there is a different presupposition in operation here and note that attention will be paid to 'groups' rather than the needs of individuals. In Foucault's terms, and given the ability of governments and agencies to harness technology to harvest large amounts of data on all of us, it is hard not to see this initiative as a massive expansion of surveillance and the 'gaze' of the state, with increased rules and sanctions imposed on recipients of income support.

How has this representation of the 'problem' come about?

The representations of unemployment (or unemployed people) and 'youth' as problems have existed for centuries. We can consider, for example, the establishment of workhouses in the nineteenth century as attempting to mitigate absolute poverty but also representing a moral imperative that the idle poor should be required to undertake labour in order to receive support.

Bacchi charts the evolution of unemployment policy in Australia from the mid-twentieth century, when unemployment benefits were introduced with a conditional 'work test'. She notes the increasing rules (governmentality) attached to these payments, particularly for younger people, with the introduction of the very restricted Youth Allowance and mandatory participation 'activity' requirements. The Work for the Dole (WFTD) program was introduced in the 1990s, requiring people aged 16-24 to work in community agencies for up to 20 hours per week. This in fact meant that even with a small supplement, participants were working for an hourly rate far below minimum or junior rates – a workhouse without walls?

This demonstrates an example of young people being treated as a separate minority group. The same can be said of much public discourse about young people and youth 'culture' over many decades. As a young child in England, I have very clear memories

of being warned about the Teds, also known as Teddy Boys, the youth menace of that era. The Teds morphed into two subcultures, known as the Mods and Rockers. These groups were cast into weekend brawls with each other in seaside towns, largely as a result of the publicity and provocation afforded by tabloid newspapers who then reported the fights in sensational detail (DeGroot 2008).

The example of the Mods and Rockers neatly illustrates how young people or groups of 'youth' have been problematised. Much of this has occurred through popular media, which identifies trends, echoes and amplifies them and often exploits them for gain; either in lurid stories or to generate advertising revenue for products targeted at particular groups.

The Mods and Rockers were succeeded in the public imagination by various dubious and work-shy subcultures; for example hippies, punks and feral greenies who have all provided endless fodder for the media. It seems it is much easier to portray these groups as the problem rather than the larger picture of a lack of jobs and opportunities.

What is left unproblematic in the problem representation? Where are the silences? Can the 'problem' be thought about differently?

As I have mentioned, Australia currently lacks a national youth employment strategy. Youth unemployment has been addressed by proposals to make income support harder to obtain, apparently providing greater incentives for people to make greater efforts to find work. This suggests that government responsibility, or the notion of government action, is left unproblematic, as is a degree of market failure in providing jobs and training opportunities.

In 2011 the Labor Commonwealth Government announced and implemented a national strategy called Building Australia Future Workforce (BAFW). The strategy incorporated a range of measures, including additional funding for training and apprenticeships, changes to eligibility for some income support payments and 'place-

based' initiatives. The latter were a set of pilot programs in selected disadvantaged local government areas. School leavers and young parents were required to undertake additional participation activities including completion of Year 12 studies.

Overall, BAFW represented an attempt at improving employment outcomes for young people, albeit with a mixture of both incentives and sanctions such as compulsory income management. Unfortunately we will never know what outcomes were achieved as the Coalition Government elected in 2013 ceased the evaluation of the initiatives (DEEWR 2011 & 2014).

Bacchi anticipated the intentions of BAFW and more recent Budget proposals in her view of how unemployment is represented:

> …the 'problem' of unemployment is represented to be due to the character and behaviour of the unemployed…Something is held to be amiss with the nature (character) of the supply of labour (the workers themselves). This is why the unemployed are said to need training and assistance in getting themselves 'job ready' (Bacchi 2009, p66).

In regard to what are the 'silences', Bacchi notes that the issue of poverty associated with unemployment is rarely mentioned. This certainly appears to be the case in regard to government policy on the level and indexation of unemployment benefits. In 2015, the poverty line in Australia for a single person not in the workforce was $827.34 per fortnight. This is considered to be the very minimum amount which will meet an individual's costs for housing, food, utilities and health (Melbourne Institute of Applied Economics 2015). The corresponding fortnightly rates of benefits for this period, including maximum rent assistance, were $652.80 for Newstart Allowance and $556.20 for Youth Allowance.

One could add that unemployed people themselves are silent and have little opportunity to directly represent the issues they face. However, groups such as the Councils of Social Services (COSSs) are vocal advocates for the alleviation of poverty

and disadvantage and have long argued (most recently in October 2015) for a minimum $50 a week rise in Newstart and Youth Allowances (ACOSS 2015).

To illustrate how problems can be thought about differently, Bacchi suggests exploring the language used to represent problems. She identifies that issues and groups are often described as binaries, such as 'welfare dependent/independent'; these descriptions both narrow the possible interpretations of an issue and ascribe that one side is superior to or more important than the other.

It is pertinent that the COSSs have focussed on this use of language in their call for national action to tackle poverty and inequality:

> This must also involve changing the way we talk about people in disadvantage. We must stop the practise of demonising and belittling people who are struggling to make ends meet, particularly in the media and in politics. The language of leaners, rorters and scroungers needs to change. Instead, we need to start talking about creating opportunities for all people in Australia, rather than seeking to separate and divide our community (ACOSS 2015, p2).

I suggest that the use of binary terms severely limits the potential for considering more thoughtful and nuanced options to address problems. This language is not only used by conservatives but also by 'progressive' commentators. So one can be either pro-feminist or a misogynist, a climate change believer or denier. The quasi-religious nature of the last pairing should not go unremarked.

The ACOSS statement very much reflects my experience working with clients in the Social Security and Centrelink agencies. The evidence over many years was that a very small number of people were defrauding the system although there was certainly a few more who appeared to be malingering to some degree. Most of the people I saw who had been reliant on income support for a long period of time wanted to go to work or return to study. However, they had usually grown up experiencing multiple adversities and continued to struggle with poverty and their own social, physical and mental health issues.

What effects are produced by this representation of the 'problem'?

In the next chapter I will argue that neoliberal political and economic philosophies have for some time worked towards reducing or dismantling the provision of welfare by the state; at the same these philosophies are boosted by the narratives of individualism and self-reliance. Blaming people for their predicament, in spite of the very high rates of youth unemployment, can appear to be a useful substitute for doing anything that will actually help them.

Probably the most negative effect of the stigmatisation of unemployed people has been the slow erosion of the real value of benefits and the refusal by successive Commonwealth governments to address this. The narrative is either that the payments are only supposed to be short-term, for people between jobs, or that low payments will be an incentive for people to find work.

I will also argue that aspects of mental health policy and practice promote a narrative of individual distress. The effect produced by this is a disproportionate (and large) allocation of resources to clinical services, by comparison social and community support services struggle to survive or expand.

How/where has this representation of the 'problem' been produced, disseminated and defended? How could it be questioned, disrupted and replaced?

The negative representation of the poor and unemployed is hardly new. 'Images of Welfare', a book published in 1982, examined historical debates in Britain about the merits or otherwise of alleviating poverty, going back to the 'Poor Laws' of the eighteenth and nineteenth centuries (Golding and Middleton 1982). A significant part of the book analysed the public and media discussion about welfare during the 1970s, when various political and economic gyrations led to high inflation and a rapid increase in unemployment. Similar events also occurred in Australia during that period.

The authors suggested a number of factors had contributed to the undermining of what had been a broad consensus about the welfare state and the role of

governments. Many low- and middle- income people were feeling the pressure of rising prices and falling wages; at the same time more government revenue was needed to support increasing numbers of individuals and families. A quantitative content analysis of mass media articles on welfare showed a bias towards reporting fraud and alleged maladministration. While the bulk of social security expenditure was on child benefits and old age pensions, the majority of stories covered unemployment benefits and cases of the alleged unwillingness of unemployed people to look for work.

The portrayal of unemployed people, particularly the young, by Australian mass media is little different. Perhaps the most durable example is the 1996 portrayal of the three Paxton siblings by a 'current affairs' television program which is still referred to in media studies (Hetherington 2012). This story involved the two brothers' and the sister's indigent lifestyle being recorded in detail. All three were then flown to a holiday resort in Queensland, some 3,000 kilometres from their home in suburban Melbourne. After a few days of leisure they were offered jobs at the resort, which they ultimately declined. The premise at the beginning that they were work-shy, was therefore 'proved', in spite of the rather obvious evidence of their lack of skills to undertake the work being offered.

Past and present proposals for welfare reform in Australia have focussed strongly on getting people back into the workforce, be they older people, parents or DSP recipients. On the surface this appears a desirable aspiration, especially in buoyant economic conditions. Given the low level of payments compared to even minimum wages, many people will be financially better off from working. The representation of the issue of 'welfare dependency' can also mask a less benign agenda, such as 'the war on the poor':

> 'Welfare dependency' creates unsustainable fiscal burdens on hard-working taxpayers. According to this narrative, 'welfare dependency' led to life in an 'underclass' of loafers, criminals, addicts and the mentally ill. It is the very expression of anti-social disorder and immorality. This discursive move relied on social science-based representations of unemployed and low income people as different from 'ordinary people' and possibly even a threat to our economy and

> certainly to the ethical order that the regime of wage work had for so long served to embody and to secure (Marston 2008, p361).

This narrative appears to be pervasive, despite the evidence of high and increasing youth unemployment. As to how it can be questioned and replaced, at least some non-government actors are adding their voice:

> An extended period out of the workforce for a young person in this most formative period of their lives places them at risk of a life sentence of poverty and exclusion from the mainstream of our society. If we invest in our available pool of young workers, we all benefit as a society and economy. Excluded people cannot contribute productively to our society, which adversely affects prospects for national growth and represents an avoidable dollar cost to public services. The solution is clear: invest in young people now, harness their ambitions, develop their capacities – and we will save in the long term. This national task is as vital as building roads, railways and ports (Brotherhood of St Laurence 2014, p6).

As I stated at the beginning of this chapter, it appears that there is a deliberate ignorance of the issues facing young unemployed people and the effects of this on their mental well-being. There is also very little current and detailed research on the effects of poor mental health on young people's capacity to participate in employment or education. In the next chapters I will address gaps in policy, knowledge and research and what might be done to replace the current paradigm.

5. DISCUSSION – GAPS IN KNOWLEDGE; PROPOSALS FOR ALTERNATIVE POLICIES

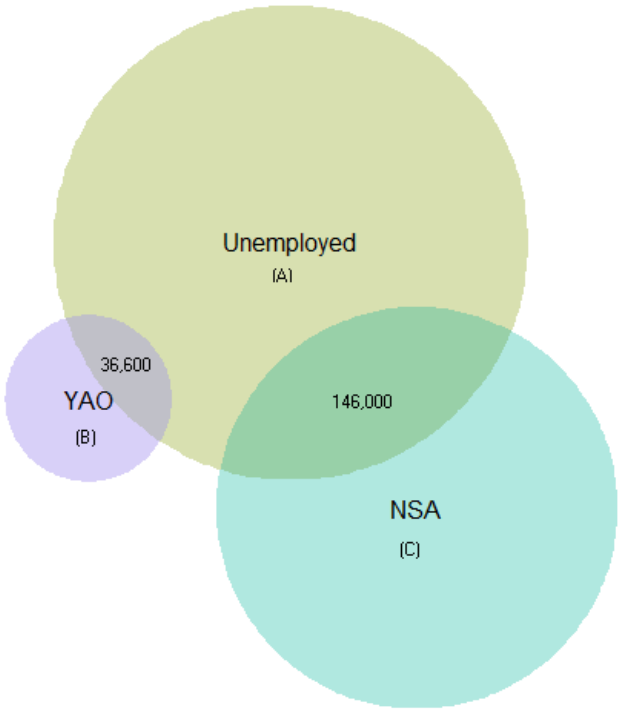
5.1 Introduction – exploring associations

In the literature review I discussed the difficulties in measuring the extent of unemployment and underemployment. An associated difficulty is identifying the number of young people who are unemployed or partially employed and are precluded from receiving income support due to parental income or other circumstances.

The Australian Bureau of Statistics appears to acknowledge the limitations of the monthly survey measure of unemployment, which counts a person as employed even if he or she has only worked for an hour during the survey period. The ABS Survey of Income and Housing provides a more detailed illustration of the extent of unemployment and the relatively low number of unemployed people who receive income support:

> Figure 1 shows that while there is a group of individuals who were unemployed and received a government job seeker income support payment in 2011-12, the majority of the unemployed were not receiving NSA or YAO. It also shows that not all people receiving NSA or YAO were classified as unemployed according to the ABS definition. In 2011-12, just over one-third (36%) of these recipients were defined as unemployed, with the remaining recipients classified as employed (26%) or not in the labour force (38%). Furthermore, the SIH estimates that only 30% of all unemployed people were receiving NSA or YAO in 2011-12.

Figure 1. VENN DIAGRAM OF THE UNEMPLOYED AND RECIPIENTS OF NSA AND YAO: 2011-12.



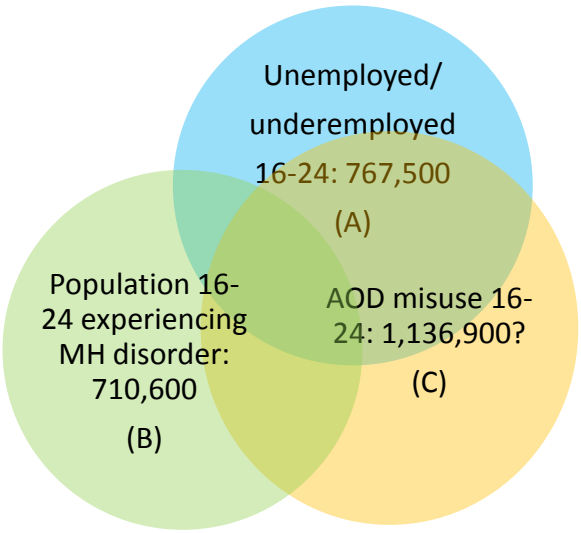
A: Unemployed = 613,700

B: YAO = 71,400

C: NSA = 434,500

(ABS 2014)

The literature has also demonstrated the limited data on how anxiety and depression affect young people's ability to participate in employment and education, as well as how many unemployed young people experience mental distress and comorbid alcohol or drug use. Using a similar Venn diagram, I shall attempt to represent this population. The figures are based on the estimated population of 2,842,400 16-24 year olds in Australia (ABS 2014); my estimates are approximate and rounded up or down to the nearest 100.



The circle (A) represents the proportion of the total population who are 'officially' unemployed, around 13%, and those who are underemployed and not in education. Using the 2013 COAG data, this would represent a combined total of 27% of the population – 767,500 people.

Using the National Survey of Mental Health and Wellbeing data, 25% of the total population aged 16-24 will have experienced or are experiencing a mental health disorder – 710,600 people (B). Assuming that at least this percentage of unemployed young people are experiencing anxiety and/or depression (and some literature suggests much higher prevalence in unemployed populations), then the number in the overlap of (A) and (B) would be a *minimum* of approximately 192,000 people.

The data from the Australian Institute of Health and Welfare on risky use or misuse of alcohol or other drugs suggest that this affects approximately 40 % of the adolescent and young adult population – 23% in regard to frequency and amount of alcohol consumption, including binge drinking, 12% in regard to use of illicit drugs and 5% in regard to recreational use of pharmaceutical drugs. This could therefore represent as many as 1,136,900 people out of the total population aged 16-24 (C) (AIHW 2013).

I suggest that the estimate of (C) might be somewhat generous, or indeed ungenerous. The definitions of risky use are somewhat broad, for example exceeding

'safe' levels of alcohol consumption once a month or more, or using any illicit drug or prescription medication for recreation. It would also seem very likely that many people with serious issues of dependence will be using a combination of substances and would therefore represent perhaps 10-15% of the total population – approximately 284,000 to 426,000 people. The data on users of *headspace* mental health services suggested that approximately 30% of clients reported issues with their use of cannabis. Based on this single comorbidity figure the minimum population in the overlap of (B) and (C) can be estimated to be approximately 213,000 people.

The population who experience the overlap of unemployment, mental health disorders and substance misuse is difficult to calculate, however I suggest they would number in the scores of thousands. I also suggest, like my former Centrelink clients and the subjects of the Christchurch Survey, that this group will have experienced significant adversities in childhood and adolescence. While experiencing these adversities and being more likely to have experienced episodes of anxiety and depression, many will not have accessed mental health services

I have produced these very rough estimates to demonstrate the lack of good data about the groups of Australian young people who are likely to be over-represented in the unemployed or under-employed population as well as experiencing multiple disadvantages. This lack of data or contemporary research seems surprising, especially given that the current National Mental Health Plan (2009-2014) had prioritised improving the integration of services, including employment support, as part of effective recovery strategies. I suggest that the lack of data, research and policy work is symptomatic of a lack of coordination between government agencies and in particular an apparent unwillingness to consider the associations between unemployment, social disadvantage and poor mental health. The absence of government action stands in poor comparison to work being done by nongovernment agencies such as the Brotherhood of St Laurence.

Recently, there has been some positive movement towards service integration. In November 2015 the Commonwealth Government announced a response to the National Mental Health Commission's report of 2014, which had called for a major

overhaul of funding and service provision (NMHC 2014). The 2015 response proposes some specific actions in regard to youth mental health, including better coordination of services based around individual needs and some renewed focus on participation:

> A trial will be held of a new model to better integrate employment and educational support for young people up to 25 years old who have a mental illness. Through the Department of Social Services, employment specialists will be integrated into youth mental health services to help individuals find work or achieve their education goals (DoH 2015).

In regard to addressing the social determinants of mental health, a good example of what could (or should) be done by government is the series of 'Dropping Off The Edge' reports prepared by the Jesuit and Catholic Social Services agencies (Vinson & Rawsthorne 2015). Detailed research has been undertaken over a number of years into place-based (geographic) disadvantage. A total of 22 indicators were measured, including housing, education, income, employment and mental health. The researchers specifically acknowledge the perspectives of SDH in guiding the investigations, the association between social and economic factors and comparisons between locations. The issue of offending in disadvantaged communities was also examined, unsurprisingly it was found that:

> In two-thirds of those localities in New South Wales *criminal convictions* were a dominant characteristic, and *adult imprisonment* and *juvenile offending* were at significantly high rates within communities additionally burdened by *long and short unemployment, disabilities, lack of formal qualifications, deficient education generally, low family incomes, domestic violence and mental health problems* (Vinson & Rawsthorne 2015, p9).

Many of the recommendations contained in this report are relevant to this research and these will be discussed later in this chapter.

An example of comprehensive research that was auspiced by government through the National Mental Health Strategy is the national survey of people living with psychotic illness (Morgan et al, 2011). A random sample of 1,825 people with a diagnosis of psychosis was interviewed in depth. The interviews covered many aspects of individuals' lives including usage of health and social services, physical comorbidities, alcohol and drug use and social connectedness. As might be expected the survey indicated significant problems associated with illness, including physical comorbidities

often associated with the side-effects of medication, very high rates of tobacco and cannabis smoking and social isolation. This report is cited because of its relevance to the current research – I suggest that if a similar study of young people living with anxiety and depression were conducted it would very likely produce similar, if less severe, associations and results.

5.2 Exploring the representations of anxiety and depression

In earlier chapters of this research I have discussed a number of aspects of the representation of anxiety and depression and in particular the difficulties in differentiating distress and disorders from illness. This is a particularly important consideration in any attempt to understand how social determinants influence mental distress or the degree to which normal life experiences such as stress or feeling sad might be over-diagnosed into a medical or psychological disorder.

In the previous section I have attempted to illustrate some of the associations between mental health disorders and personal and social factors, including unemployment. The literature also demonstrates convincing evidence that prolonged unemployment is generally not beneficial to a person's wellbeing.

The representation of an 'epidemic' of anxiety and depression affecting one in four young Australians is troubling for two reasons. Firstly, it is an indication of widespread unhappiness which seems at odds with Australia's self-image as a very prosperous and generally peaceful nation. Secondly, I believe there is a problem in generalising the range of distress and symptoms people experience into a single statistic.

Gordon Parker from the Black Dog Institute argues that the diagnosing of depression requires careful differentiation. He describes depression with its origin in biological and biochemical causes as 'melancholia'; this frequently responds well to medication. Other manifestations of depression with causes such as life events will be less likely to respond to medication (Parker 2013). On ABC Radio, Parker said:

> Depression can range from sadness and sort of a melancholy-type temperament, through to disorder level through to quite severe diseases. And the problem is across that spectrum it's very easy for people to just come up with a single concept of depression and then take it even further and pathologise normal states of depression and call everything clinical depression…For the last 30 years, particularly with the Diagnostic and Statistical Manual from the US psychiatrists, melancholy has been simply positioned as a more severe depression. The problem with that is there are many people with non-melancholic depression that have very severe states and there are people with melancholic depression where it just trudges along at a low level. So it shouldn't be diagnosed simply on the basis of severity (Parker 2015).

I have previously noted that Australia has the second-highest usage of antidepressant medication among OECD countries. If indeed much of the experience of anxiety and depression is determined by personal and social circumstances, then the efficacy of pharmacological remedies must be questioned. This is supported by a meta-analysis of a large number of clinical trials, which found that there was little evidence to support the use of medication for individuals with mild to moderate depression. The authors concluded that:

> Considering the extensive use of drugs for emotional complaints in absence of a diagnosis of major depression, shifting from drugs to psychological interventions would require investment in human resources, training and supervision, as well as additional time for healthcare providers to deliver the interventions. In systems with no or low resources doctors should still shift away from drug intervention as resources may be better spent elsewhere in the health system. There is clearly a need to develop alternative approaches to extend and scale up care to persons with this condition (Barbui et al 2011, p15)

To this statement, it could be added that effective interventions should not be the sole province of healthcare providers, particularly given the symbiotic relationship between pharmaceutical manufacturers and medical and psychiatric practice. As the bioethicist Nikolas Rose has argued, the evolution of more elaborate classifications of mental health disorders (the iterations of the Diagnostic and Statistical Manuals) has driven the research and development of new psychotropic drugs. The availability of these medications has in turn driven the expansion of diagnoses and putative treatments for what may well be distresses caused by social and economic circumstances; Rose describes this as the evolution of the 'neurochemical self' (Rose 2007). I think a good analogy for this is the leapfrogging of developments in computer

hardware and software since the 1980s. As operating systems, programs and applications such as internet tools become more sophisticated, faster computer processors and bigger memory capacities are required to run them. The improved hardware then provides for the development of more sophisticated applications which then drives demand for the upgrading of hardware, and so on. We can observe parallels in regard to the expansion of the definitions of psychological and behavioural disorders, for example Attention Deficit Disorder, and the increased marketing and prescription of drugs such as Ritalin to treat the 'disease'.

The reforms to mental health care proposed in 2015 incorporated reallocation of Commonwealth-funded programs and coordination by the new Primary Health Networks (PHNs), the successors to the General Practice Divisions and Networks. It is anticipated that PHNs will work closely with State and Territory acute mental health services, as well as with *headspace* centres which have been autonomous within their own national organisation. It is not clear how much authority the PHNs will be given to determine resources provided to individuals and exactly how they will work more effectively with other, non-health, services.

Addressing the social determinants of mental health requires coordinated action by other services including income support, housing and employment. In the next section I will explore the challenges that exist for health professionals and other providers in working with unemployed and marginalised young people.

5.3 Sharing the responsibility

As has been discussed in the literature review, general practitioners (GPs) play a significant role in the assessment and treatment of the high prevalence mental health disorders of anxiety and depression. The GP Mental Health Treatment Plan is for most people the entry point for referral to psychiatrists and allied mental health services. GPs also provide evidence for patients claiming income support on the basis of incapacity or disability. This work presents challenges for GPs, who are mostly private

practitioners, with limited abilities to provide extensive consultations or referrals to other services.

In 2008 the Commonwealth Government commissioned the Hunter Institute of Mental Health to research how GPs and mental health nurses could better support employment for people with mental illness. The qualitative research was conducted with focus groups of practitioners in three states (disclosure: I was asked by the Institute to recruit GPs in Adelaide and Murray Bridge and attended two meetings as an observer, I did not provide formal input to the final report) . The research used the terminology of mental illness to cover all types of mental health disorders.

The research report identified a number of issues, a key theme being communication between practitioners, Centrelink and employment service providers:

> Based on participant reports, the consultation process highlighted that GPs and mental health nurses value the importance of employment for people with mental illness, but that they struggle to capture their judgements about work capacity for people with mental illness on the current Centrelink forms. The participants also indicated that GPs and mental health nurses generally do not understand the employment support service system processes, their role in it or how they should best navigate it (DEEWR 2008, p5).

A related issue identified by this report was the need to improve service providers' understanding of mental health issues affecting individual clients. Following the publication of the report, there did not appear to have been any comprehensive strategy by Commonwealth and contracted job services agencies to implement the recommendations from the report. This appears to be a notable failing, in the light of the various National Mental Health Plans which have promoted employment as an important factor in recovery from mental health disorders.

This being said, the mental health reforms proposed by the Commonwealth in November 2015 have included a focus on employment and the trialling of Intensive Placement Support (IPS), a model of employment support for people with mental health disorders which has been undertaken and validated in a number of countries

including Australia. Orygen Youth Health, which facilitated the initial *headspace* youth mental health services, has been the chief proponent of the adoption of IPS in Australia.

In June 2014 Orygen published a major report on employment, education and young people with mental illness, entitled 'Tell Them They're Dreaming'. Many of the issues described and canvassed in this document are aligned with the scope of this research. The report is critical of the performance of Job Services and Disability Employment Services (DES) in regard to achieving sustained employment outcomes for young people with mental health disorders. It is particularly critical of contractual arrangements which appear to reward agencies for keeping clients rather than achieving outcomes:

> A DES provider gets more money for keeping someone on the books for two years without finding them a job than for quickly achieving employment outcomes. A caseload of 50 ESS funding level two clients over two years generates more than $750,000 in service fees alone which represents more than five times the two year salary of one full-time employment consultant (Orygen 2014, p39).

The report proposes reform of funding arrangements and how young peoples' needs can be more accurately assessed by providers. A number of models are investigated for promoting participation of young people with mental health disorders, including social firms, clubhouses and the aforementioned IPS.

The Orygen report argues that IPS programs, both overseas and in Australia, have provided strong evidence of their effectiveness in finding employment for people with mental health disorders. As its name suggests, the focus is on individualised support provided in a coordinated fashion by both mental health and employment services providers. The aim is to place people in open 'competitive' employment, based on individual preferences, and to provide ongoing (not time limited) personal support for job search activities and maintaining employment. IPS also requires that services are active in developing job opportunities:

> IPS providers must build employer networks and relationships through systematic contacts. This is more than calling businesses looking for openings. It refers to creating relationships with employers by understanding the business and human resources. Future contacts revolve around discussions of possible employees when good job matches arise. There is evidence that poor skills in this area are very detrimental to the effectiveness of any employment service. This is important as people suffering mental illnesses often get discouraged and give up on self-directed job searches (Orygen 2014, p46).

5.4 The Policy Landscape – Welfare Reform and 'Participation'

Earlier in this thesis I discussed two iterations of welfare reform policies, the Australians Working Together initiative of the early 2000s and the more recent proposals to streamline the income support system with a much stronger focus on moving recipients into employment. At first glance, it seems obvious that most people receiving income support would be better off working, especially as even minimum wage full-time employment will provide much greater income than unemployment benefits. However, the reality for many young people is somewhat more complex – many of the available jobs are part-time or casual and even if one qualifies for some Newstart or Youth Allowance it can be difficult to balance work and the sometimes onerous job search and other conditions for receiving regular payment. Brief periods of full-time employment, such as seasonal work, will result in a complex reapplication process for benefits, 'waiting periods' and cancellation or suspension of concessions for transport and health care.

The push to 'reform' welfare and social security has not been confined to Australia and many of the arguments for change have been imported from other nations in the Anglosphere – the United States, the United Kingdom and more recently New Zealand. The characteristics of post-World War Two expansion of welfare states, with some variations, incorporated three areas of provision: fiscal welfare (e.g. benefits and tax transfer), occupational welfare (e.g. setting of wages and conditions) and social provision (e.g. health and housing). These provisions were in general supported by

governments across the political spectrum, representing a social compact that the benefits of post-war prosperity should be shared (Mann 2008).

Global economic conditions changed rapidly in the 1970s, initially caused by the 'oil shock' when the Arabian petroleum producing countries cut production with a resultant sharp increase in prices. The rapid inflation caused by this placed great pressure on government budgets; at the same time unemployment was increasing due to industrial and technological change. Paradoxically, this was the period during which much attention was given to unemployed people and the perceived burden that their increasing numbers placed on the state.

This period also saw the ascendency of neoliberal governments – the Fraser Government in Australia (1975), the Thatcher Government in the UK (1979) and the Reagan Administration in the US (1980). One author has argued that the oil shock was instrumental in this political and economic shift, having demonstrated that essential resources could no longer be controlled by governments:

> …the usefulness of resource economics was its contribution to defeating Keynesian economics, by undermining arguments for government regulation and proposing a neoliberal alternative: that the problem of the putative exhaustion of oil reserves can be overcome by market arrangements. This was not an argument for abstract forces of the market: it was for the deployment of a political technology, for that is what the neoliberal market projects offered (Mitchell 2010, p200).

A core philosophy of neoliberalism, influenced by economists such as Friedman and Hayek, was that government should get out of the way of the free market, public assets should be privatised in the name of efficiency and both taxation and spending should be reduced (Clarke 2004).

One consequence of the neoliberal trend was the emergence of 'welfare to work' or 'workfare' policies. The Australian iteration of this has been documented by McDonald and Marston (2006) and Marston (2008).

> …mutual obligation policy merges neo-liberalism and new-paternalism as it is based on both contractual and paternalist rationales. The contractual rationale rests on the idea that the government provides financial support to people looking for work and in return, these people are morally required to put something back into their community. The paternalist rationale asserts that the unemployed benefit from participating in mutual obligation programs as it enhances their job prospects.
>
> Since 1999 the Australian Government has sought to extend the principle and practice of mutual obligation to more groups within the community. From July 1, 2006 people in receipt of sole parent payments and those people with a disability deemed capable of work will be drawn into the government's narrowly defined 'participation agenda'. Workfare in Australia represents a fundamental re-fashioning of the regime choices Australia made in the early part of the 20th Century, and coupled with the dismantling of centralised wage fixing, the 'wage earners' welfare state' (Castles, 1985) has been rendered an historical artefact (McDonald and Marston 2006, p173).

The data on unemployment show that in some regions of Australia rates of youth unemployment are alarmingly high and persistent. The many studies of unemployed populations demonstrate that prolonged unemployment is associated with poorer mental health. It would be reasonable to summarise neoliberal policies as ignoring these realities, unemployed people are so because of their own deficits and failings. Policies to date have thus focussed on individual compliance, such as jobseeker diaries and Work for the Dole programs, with scant regard for the actual circumstances of participants and whether such activities may be detrimental to those already experiencing mental ill-health. An alternative approach might view youth unemployment as a public health issue, for example by investing in job creation and training to prevent the personal and social ill-effects of unemployment. As the 'Tell Them They're Dreaming' report says:

> To continue to fund systems that do not and have not worked for people with mental illness is a disservice to a population eager to work and must be seen for the wilful wastage that it is.
> Reducing isolation, financial disadvantage and other problems associated with mental illness is not only vital to improving the lives of young people with mental illness but also to improving productivity and sustainability of the Australian economy and society (Orygen 2014, p11).

5.5 Mental health reform – integration at last?

Some elements of the Commonwealth Government's proposals for national mental health reform announced in 2015 have been described above. In this section I will attempt to highlight and analyse some of the potential challenges in integrating services across levels of government and nongovernment agencies. I will add that at the time of completing this piece of research the reform process had not yet commenced so any concerns I have raised are speculative.

The reform process does not appear to provide additional funding; rather it is reallocating existing Commonwealth program resources, such as Better Outcomes and Youth Mental Health (*headspace*) funds to the Primary Health Networks. The State and Territory local health and hospital networks are identified as an essential component of coordinated regional services but there is no mention of additional resourcing for this sector, either for planning or improving acute care services. In the case of South Australia, there is one PHN covering all of metropolitan Adelaide which would be required to liaise with three SA Health networks, each with their own mental health directorate.

The issue of governance may also be interesting in regard to planning and allocation and location of services. The reform factsheet (DoH 2015) states that the PHNs will take the lead in planning, however it is difficult to imagine State and Territory agencies giving up authority over their own resources. Similarly, organisations such as *headspace* and Aboriginal health services have been highly autonomous with their own 'brand' identities and national structures; I imagine that they too might be somewhat unwilling to change the status quo.

The reform process has not suggested any changes to the funding or operation of Better Access (Medicare funded) mental health services. This would appear to be a missed opportunity to better facilitate the relationships between GPs and allied health practitioners, and other services including Centrelink and employment agencies.

As previously mentioned, the reform process acknowledges the need to integrate mental health and employment services. The Commonwealth will be allocating funding to the PHNs for alcohol and drug treatment services which most likely will be contracted out to existing nongovernment providers (Lee 2015).

The Commonwealth Government has provided quite specific detail about what is to be undertaken from 2017 onwards:

> The Government will:
>
> • undertake a trial of specialised employment support, led by the Department of Social Services, to assist young people up to the age of 25 with mental illness in addressing their educational and/or vocational goals. Professional employment specialists will be integrated into youth mental health services under an Individual Placement and Support model to better integrate employment and educational support with mental health services;
>
> • ensure *headspace* and other youth mental health services are integrated at a regional level with primary care services through PHNs, and support young people impacted by substance misuse; and
>
> • explore opportunities to use available youth mental health funding to provide early intervention for a broader group of young people who present to primary care services with severe mental illness or [are] at risk of such.
>
> Broader employment support initiatives are also underway. This includes a trial to test a participant-driven employment assistance model with young people in Disability Employment Services (DES) with a mental health condition, led by the Department of Social Services. Additionally, the introduction of jobactive, (through the Department of Employment) will provide jobseekers, including those with a mental health issue, with access to tailored assistance in finding and maintaining employment (DoH 2015, p16).

5.6 Summary – what is missing?

Having developed the ideas for this research over more than a decade, I believe the reforms announced by the Commonwealth Government in 2015 validate the importance of the research topic and in particular the need to better integrate mental health and employment services for younger Australians. While the reforms represent an opportunity for this integration, the social determinants of mental health are barely addressed. The focus remains on individual therapy via a GP mental health treatment plan.

The ABS data used in the introduction to this chapter illustrate that a significant proportion of unemployed people do not receive income support. As I have discussed elsewhere, access to Youth Allowance (for people under 22 years of age) is particularly restricted by parental means even if parents are not actually providing support. Lack of, or very low income, is a factor that exacerbates social exclusion and makes looking for work or participating in education and training more difficult.

I have attempted to estimate the proportion of younger Australians who are unemployed or underemployed, experiencing poor mental health and, in many cases, comorbid alcohol and drug use. I would suggest that most people in this population also experience poverty and other adversities that mean they are much less likely to access mental health support from a GP or other services. From my experience working with younger unemployed people, I suggest that many would not see themselves as having a mental health disorder, but rather a difficult life.

So there is at last a worthy attempt at service improvement, but no policies that are attempting to address the causes of the poor mental health of many young Australians. This stands in poor contrast to other public health measures, such as tobacco control or the prevention of sexually transmitted diseases. In the next chapter I will briefly outline ideas for a further research project that would investigate different approaches for engaging and supporting people.

6. IDEAS FOR FUTURE RESEARCH

6.1 A rationale for looking beyond policy research

This research has focussed on policy and highlighted the social determinants of mental health. It is therefore possible to consider doing further research on the extent to which social exclusion contributes to the poor mental health of many young Australians and how the factors that cause social exclusion might be alleviated. I believe this research has been able to identify contemporary data about the extent and impact of unemployment on young people and has demonstrated strong associations between unemployment, mental health disorders and comorbid substance misuse.

I have also argued that successive governments have missed opportunities to address these problems. There is no national strategy for the promotion or creation of employment for younger Australians. While there have been positive developments in recent years, such as the introduction of vocational education in high schools, the privatisation of the Vocational Education and Training (VET) sector does not seem to have provided much benefit to young people. Indeed, during 2015 there was emerging evidence of questionable (if not fraudulent) practices by VET providers including very poor quality training and accountability. Courses have been marketed to vulnerable people with incentives such as 'free' laptops, with the individuals who signed up being unaware that they were also incurring significant Commonwealth FEE-HELP debts (The Weekend Australian 2015).

Other policies which allegedly motivate younger people to participate in employment are questionable. The proposals in the 2014 and 2015 Budgets to restrict already minimal income support payments to young people were presented as a 'savings' measure - certainly the intended target groups would be saving by not buying such items as food and clothing. In my view, such policies are not only vindictive but also counter-productive: how can young people be expected to undertake job search activities or training without access to even basic resources such as communications and transport?

I believe the fact that such policies can be proposed, and not receive widespread condemnation, illustrates a deeper malaise in government and what remains of the welfare state. In late 2015 Laura Tingle, a Canberra political journalist and editor, published a lengthy essay about what she views as the demise of effective government and policy-making in recent decades. Tingle suggests that several factors have led to this, including neoliberal economic philosophies, the destruction of expertise in the public sector and politics focussed primarily on managing 'issues':

> But elements that I think are regularly overlooked are more fundamental: the role of memory and the changing nature of risk-taking in politics. I argue that there is a growing loss of institutional memory about *how* things have come about, and, more importantly perhaps, *why* they did.
>
> Without memory, there is no context or continuity for the making of new decisions. We have little choice but to take these decisions at face value, as the inevitable outcome of current circumstance. The perils of this are manifest. Decisions are taken that are not informed by knowledge of what has worked, or not worked, in the past, or even by a conscious analysis of what might have changed since the issue was last considered (Tingle 2015, pp 4-5).

It is tempting to more extensively quote parts of this essay, which accord with the general thrust of this thesis. The key message for the purpose of this discussion is that in the current political discourse, there may be little point in conducting even the most thorough research into what is not working for a significant group of young Australians, in the absence of anyone being prepared to take note and action. I have previously mentioned the Business Council of Australia's call for a modest increase in unemployment benefits on economically rational grounds, i.e. actually enabling citizens to survive above the poverty line and effectively look for work. There was no response from the Coalition Government to this request, even though the BCA might be seen as a natural ally. It seems unlikely that any academic research in this field would be any more successful in effecting policy change.

This, then, raises the question of what further research could be effective. I believe there are two key principles that can guide such research. The first is that research addressing better integration of services is grounded in the exploration and testing of how agencies can actually do this at a local or regional level. The second is involving participants (young people aged 16-24 years), to demonstrate what may or may not

work, and thus provide findings that can be readily replicated and transferred. In the next section I will discuss what the Intensive Placement Support (IPS) model can offer as a foundation for new research; in the following section I will outline aspects of what this new research could look like.

6.2 Intensive Placement Support as a foundation for future research

In the course of undertaking this research I have striven to find the right 'elevator conversation', to be able to outline my work in a sentence or three. One portrayal that I have found useful is that many mental health practitioners will ask their clients "How are you doing?" or "How are you feeling?", when they should also be asking "*What* are you doing?" The IPS model encompasses this additional focus on participation as a major or indeed essential factor in a person's recovery from a mental health disorder.

The IPS model promoted by Orygen Youth Health describes mental health clinicians and services as central to the initial identification of individuals with mental health disorders. Evidence from Australia and other countries is cited that emphasises the importance of also having specialists in employment services, with sound knowledge and skills for working with these individuals.

The Orygen discussion paper provides a powerful case for better integration of services to help young people into employment and more widespread establishment of IPS programs. My main reservation about what is proposed is that it still uses the terminology of 'mental illness' and appears to rely heavily on clinicians conducting the initial assessment and referral.

In the previous chapter I have attempted to demonstrate the significant number of unemployed or underemployed young people who experience mental health disorders and/or comorbidity substance misuse. I suggest that while some individuals in this population do seek assistance from GPs and mental health services, many do not seek help or simply do not have accessible local services. I am therefore proposing that research needs to be conducted into a modified version of IPS. This would

investigate and address the needs of young people who are engaged with Centrelink and employment services but, for whatever reason, have not approached GPs or other services such as *headspace*.

6.3 A proposal for Participant Action Research using a modified model of IPS

As I have noted above, the current consideration of the application of IPS uses a medical/clinical model for assessment, treatment and support. The alternative proposal suggested here outlines an adapted research framework that can be conducted in a discrete location, with manageable numbers of agencies and participants. The hypothesis is that a modified form of IPS can be shown to be effective and calibrated to individual requirements, including young people who may not have accessed any mental health services, or had a formal diagnosis of anxiety and/or depression.

During 2015 I had some preliminary discussions with possible stakeholders and the research idea is supported by my current supervisor at Flinders University as a PhD topic. If the research were to commence in mid-2016 it would align well with the development of integrated mental health service models, as proposed by the Commonwealth Government and to be undertaken by the Primary Health Networks.

In this section I will briefly describe some elements of the proposed research and some issues that would need to be addressed in undertaking the project. Establishing the research will include the negotiation of processes and protocols and ethics approvals as required by participating agencies. In order to clearly identify my activities I shall refer to myself as 'the researcher'.

The research would seek to engage as wide a range of services as possible, including mental health, employment and community support agencies. Consideration has been given to two locations which are accessible and socially and economically diverse – outer southern Adelaide (the City of Onkaparinga) and the rural city of Murray Bridge. There are many youth-specific agencies in both of these areas, including

headspace centres. The Adelaide PHN covers Onkaparinga and the Country SA PHN covers Murray Bridge.

Unemployed or underemployed people aged 16 to 24 will be recruited from agencies who have agreed to take part in the research. For the purposes of the research, agencies will be asked to identify participants who have been unemployed for at least six months and who have identified, or been identified as experiencing, adversities such as insecure accommodation or lack of family support. Participation in the research is to be entirely voluntary and participants will be free to exit the research project at any time. A key principle underlying the research is 'no wrong door'; that is participants should be offered assistance and the opportunity to take part in the project regardless of which partner agency they have first contact with. The research would also provide opportunities for employment services to improve their knowledge of mental health issues, increase the skills of their staff and access support from other agencies when required.

The IPS framework stresses the importance of clients having choices about what kind of services they receive and what activities they undertake. This should therefore also be a guiding principle for confidentiality and information sharing, that is the participant has control of what is shared and with whom. In the course of the research this issue would also be addressed and reviewed by including participants in case conferences/discussions.

Obvious and measurable outcomes would be the number of young people who are able to be assisted into employment or education, and improvements in their mental health and well-being. Other qualitative improvements for participants and processes could be further developed and negotiated with partner agencies.

I anticipate that there will be some challenges in obtaining ethics approvals from diverse agencies. A recent research project conducted in Adelaide, Comorbidity Action in the North (CAN), required multiple ethics applications and site specific approvals which took up nearly the first year of a three year project (Posselt et al

2014). Progressing approval will therefore be a high priority in planning the proposed research.

6.4 Conclusion

Some years ago when I began to consider undertaking this research, I discussed the topic and scope with a number of people working in the fields of mental health and social policy. A benefit resulting from those discussions was my realisation that the subject of the research was potentially massive and I needed to refine the research question, the population to be studied and the key issues.

The problems of the high rates of unemployment and poor mental health amongst younger Australians are not new, as they have, so to speak, been under our noses for several decades. I believe this research has quantified the extent of the problems and, to an extent, the associations between them. I believe the research has examined the data and existing policies in a new way and has highlighted the need to consider mental health and unemployment as **public health** issues.

We might also consider reframing these issues. As I have discussed in this thesis, young unemployed people are frequently represented in a negative way, for example choosing dependency on welfare to taking a job, even though there are limited work opportunities in many regions. As an alternative approach, we could consider addressing the employment and other needs of younger people with mental health issues as an investment, and in doing so may well relieve the long-term costs of health and income support.

This research has hopefully provided a foundation for continuing research into practical approaches to improving the social and economic participation of young people with mental health problems and in turn examining how participation can improve mental well-being. Wicked problems may be difficult to solve, but this should not mean that we do not investigate and consider alternative approaches to policy and service delivery.

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