An experiential discussion of barriers to employment, long-term unemployment effects and exploration of innovative services

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Abstract: Unemployment entails a complex range of effects, from social to emotional, and biological. Social effects of unemployment can include social isolation and relationship issues, emotional effects can include mental health problems such as depression and anxiety, while biological effects can include sleep disturbance, nutritional or dietary changes as well as physiological responses to depression and anxiety. The present paper explores psychological long-term unemployment effects, including barriers to employment, from the perspective of Psychologists and Case Managers who work within the Personal Support Programme, a federally funded program of the Department of Family and Community Services. In addition to a presentation on current trends in barriers to employment, the presentation will explore innovations in service delivery to meet the needs of this client population. The presentation is designed to be accessible to professionals from the fields of mental health, community development, social work, employment sector and public services, such as Centrelink. Information packs will be distributed that contain useful resources for follow-up.

Unemployment and Mental Health Problems: Barriers to Employment

The links between unemployment and poor mental health have been well established (Harris, *et al*, 2002; Creed *et al* 1999; Rowley and Feather, 1987; Murphy and Ahtanasou, 1999; Tschopp *et al* 2001). Unemployment has been shown to contribute to high levels of depression, anxiety, social isolation, decline in general health, reduced self-esteem and confidence and sleep disturbance (Finlay-Jones and Eckhardt, 1984; Winefield *et al* 1991, Winefield and Tiggemann, 1990).

Depression and long-term unemployment

According to the Diagnostic and Statistical Manual Fourth Edition (APA, 1994), a Major Depressive Episode is usually characterised by depressed mood for most of the day, almost every day, extremely diminished capacity to enjoy life, remarkable and undeliberate weight loss or weight gain, either insomnia or conversely hypersomnia almost daily, psychomotor agitation or psychomotor retardation on most days, depletion of self-worth, extreme fatigue, feelings of inappropriate guilt, feelings of worthlessness, diminished cognitive capacity and recurrent thoughts of death and dying. The diagnosis is difficult to make, as certain combinations of symptom clusters need to be met. However, the relevant point to make is that unemployment has been shown to lead to these symptoms – has been shown to lead to depression. Currently, approximately 800,000 people per year of the Australian population are affected by depression, and while this number is high, it likely has been under-reported either due to fear, stigma, or failure to present for identification or diagnosis from a qualified professional (BeyondBlue, 2003).

Anxiety and long-term unemployment

Anxiety is another common psychiatric disorder among the unemployed population. Anxiety can take a number of forms. The most typical presentations for this client group include:

Panic Attacks

When clients present with a history of panic attacks, they describe how their heart rate increases, their breathing becomes shallow, some become dizzy due to hyperventilation and fear that they may faint or even die. They also report increase in perspiration, abdominal discomfort, chest pain and a sensation akin to pins-and-needles, which is termed paraesthesia. Panic attacks affect between 1 and 2% of the population (ADAVIC, 2003).

Agoraphobia

Clients who are long-term unemployed, and here we are referring to clients who have been out of paid employment in excess of 5 years, and who experience agoraphobia, often say that they just can't get outside. They feel overwhelmed in public places and spend most of their journey looking for exits. One client experienced agoraphobia to such an extreme, that he would only do his shopping once every four months, at the local supermarket, which was open 24hours a day. He would attend the supermarket at 3am, not only to avoid other customers, but also because the supermarket worked on a skeleton staff at that time of the night. Usually when individuals with agoraphobia have no choice but attend a public place, such as when they have to attend Centrelink to submit their fortnightly benefit form, they have a panic attack. Some clients just can't make the trip and so they risk not getting paid for that fortnight. Agoraphobia is not a fear of being outdoors, it is a fear of being around other people, especially in crowds or group settings. In Australia, 2 % of people are diagnosed with Agoraphobia (ADAVIC, 2003).

Specific Phobia

Some clients attend with phobias, or specific phobias, and report that these phobias prevent them from returning to paid employment. According to the Diagnostic and Statistical Manual Fourth Edition, the phobia is characterised by a persistent fear that is often unreasonable and that is brought about by a precipitating anxiety pertaining to a certain object or event. When a client is exposed to the fear-provoking stimulus, an anxiety response is invoked. While the client acknowledges the excessiveness of the fear, they persist in avoiding it at all costs. How does this affect the capacity of individual to return to work? Well, the phobia can be so marked that it can acutely or chronically interfere with the usual daily routine of the sufferer. The phobia interferes with the individual's capacity to participate in occupational, educational, social or relational areas of their lives. Is it treatable? Yes, agoraphobia can be treated with psychological interventions or medication or a combination approach.

Post Traumatic Stress Disorder (PTSD)

At our office on the Mornington Peninsula in Victoria, we have an uncharacteristically high proportion of our clients who identify themselves as a victim of torture and trauma. Most of these clients meet the Diagnostic and Statistical Manual Fourth Edition, criteria for a diagnosis of Post Traumatic Stress Disorder, or PTSD. These clients usually report that they witnessed a traumatic event, they experienced intense and profound fear at the time, they experience persistent night terrors and fear-provoking recollections of the event. Sometimes,

the clients also report that on occasion, they feel as if the event was occurring again – they have a sense of reliving the terror. The victims also report experiencing intense psychological and physiological distress, they avoid anything that reminds them of the event out of fear that it may trigger further stress reactions, sleep disturbance, depleted cognitive functioning and sense of feeling isolated from others. This mental health state can affect the capacity of the individual to return to the workforce or to study, as it has been found to cause clinically significant distress in situations requiring occupational, social and relational functioning.

Generalised Anxiety Disorder

Generalised Anxiety Disorder is in our experience, the most frequent presentation for this population of unemployed and long-term unemployed clients. It generally entails persistent and excessive worry for most days, for about 6 months, to such an extent that the individual has trouble controlling the worry. Clients with this diagnosis usually report feeling restless, irritable, moody and they have difficulty concentrating. In addition, they also report sleep disturbance, which can often evolve to a sleep disorder, muscular tension, headache, respiratory problems, cognitive impairment, fatigue and exhaustion. While someone with a Specific Phobia will experience symptoms in response to a particular event or stimulus, someone who is affected by Generalised Anxiety Disorder does not confine their worry to one event or object – that is, they generalise their fear. The symptoms can lead to distress of clinical significance. Most of these symptoms are accounted for in the Diagnostic and Statistical Manual Fourth Edition (1994).

Personality disorders and unemployment

A smaller proportion of long-term unemployed people are diagnosed with a Personality Disorder. These disorders can take a number of forms, though generally, people who are affected by PD usually have a pattern of behaviour or inner experiences that differ largely from what one would normally expect of their culture. They may perceive or interpret things markedly differently to other people, they may have issues around impulse control or interpersonal functioning. This can make gaining employment difficult as sometimes clients who experience these symptoms can have trouble working within organisationally acceptable parameters, or gelling with the culture of the organisation.

Social isolation and unemployment

Social isolation is a key theme associated with unemployment. When people cease employment, they run the risk of losing their immediate social networks. Some people feel that they spend more time at work with work colleagues than they do with their family. According to Feather (1989) older, unemployed males report behaviour changes after they cease employment. The participants of the study reported that they spend more time involved in domestic activities such as work (including meal preparation, shopping, household chores), domestic pastimes (including sitting around at home, watching television and sleeping during the day), reading books and gardening. Feather (1989) reported that psychological well-being was greater for participants that increased the frequency of social contact. It is possible that conversely, unemployed individuals who have decreased social contact post employment, may experience higher levels of psychological distress, including elevated depressive symptomatology.

While the effects of long-term unemployment have been documented, there appears to be a paucity in research, especially over the last decade, regarding strategies to assist individuals to

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cope with these effects and subsequently return to the workforce. A recent review of the literature available through the search engine PsychLit confirmed that relatively few investigations have been undertaken which look at programs and schemes that have been established or trialed to assist the long-term unemployed.

Programs to assist

There is a range of government and organisational initiatives that have been introduced to aid the facilitation of the unemployed person to the workforce. These include Open Employment programs such as Competitive Employment Training and Placement (CETP), Business Services (sheltered workshop), Open Employment (jobs everyone can apply for) and Vocational Rehabilitation (Waghorn and King, 1999). The programs are run nationally, and attract Federal funding. Vocational Rehabilitation programs can be funded by the Commonwealth (for example as a service of the Commonwealth Rehabilitation Service), or privately. Another Federal initiative is the Job Network, and within the Job Network is the Intensive Support and Customised Assistance program, or ISCA. Generally, to be eligible for the program, clients or customers need to have completed the Job Seeker Classification Instrument with Centrelink or have a Job Seeker Identification card. Intensive Support and Customised Assistance is targeted at clients who are deemed by Centrelink to be work-ready, and so the primary focus of the program is to support the client through job search training, one-to-one case management, group training and so on. The program is really not well equipped to manage clients who are deemed to be not work-ready. This is why the Personal Support Programme was introduced in 2001.

The Personal Support Programme (PSP) is a national program funded by the Department of Family and Community Services (DeFACS). The PSP commenced on 1st July 2002. There were initially 15,000 individuals on the program nationally. They will be increasing that number to 45,000 by June 2004. The program was especially designed to meet the needs of job seekers who were not able to effectively participate in job search activities or mutual obligation, due a range of major and complex barriers to employment. The types of barriers that PSP clients usually present with include:

- Psychological and Psychiatric
- Housing and Accommodation
- Financial Crisis
- Forensic Issues and Criminal Behaviour
- Alcohol and Other Drug Use
- Gambling and Other Addiction
- Relationship Issues (e.g. Family, Spousal, Domestic Violence)
- Long-term Unemployment Effects
- Social Isolation / Alienation
- Lack of or no Formal Skills / Education / Training

When clients are referred to the Personal Support Programme, they can choose their provider, and there are a range of providers in each Employment Service Area. Clients can be referred by the Occupational Psychologist, the Disability Officer, Social Worker and Personal Adviser from Centrelink, however most referrals are made by the Occupational Psychologist. When a client commences in PSP, they are allocated a Case Manager who assists the client to identify

their barriers to employment. Following that, an individually tailored action plan is collaboratively developed and forms the basis for the future interventions. The Personal Support Programme is advantageous for clients in a number of ways:

- Clients can remain on PSP for up to two years
- Participation in the PSP is regarded as a mutual obligation option, thereby exempting the client from job search
- Clients work collaboratively with their case manager towards their identified goals and at their own pace
- Clients can submit Centrelink benefit forms every 12 weeks as opposed to every 2 weeks.

A typical action plan for a client will address issues including client engagement, mental health, housing issues, alcohol and other drug use, education, training and employment goals.

As providers, the Personal Support Programme has inherent barriers to our ability to effect change for clients. Perhaps the primary barrier is funding. For each client, providers generally can allow for between $30 and $70 to spend on each client for each of the two years, in direct aid from the funding received from DeFACS. So, for a client who remains in the Program for 2 years, this equates to approximately $140. As these clients generally present in crisis and in need, the $70 can be spent quite quickly. For example, a client may come and ask for funding to help pay for medication, or for rent for a room for a night. After these sorts of things have been paid for, it leaves little over to contribute to the education and training needs of the client.

One of the ways that we have come to address this issue is by collaborating with other providers of the Personal Support Programme. Collaboration is a good idea, but can be initially tricky to initiate, given the competitive nature of enterprise. However, given that providers were generally in the same financial position, collaboration became a relatively smooth process. We initially collaborated with Essendon Network Employment and Training Job Futures, to develop, resource and deliver a Personal Development Programme. This program, based on a cognitive behavioural therapy (CBT) framework, looked at a variety of strategies and skills that can lead to improvements in the client's management of symptoms of anxiety and depression. Clients from both providers attended the 8 week program.

The advantages of the collaborative process included the facilitation of financial viability for the delivery of innovative services, sharing of provider resources including staff knowledge, time and expertise and office location, social interaction for clients and the overall improvement of access to resources for both clients and staff. Without the collaboration, neither provider could '*afford*' to design, deliver and resource the initiative therefore; clients may have missed out on accessing the service.

The Brotherhood of St Laurence has also developed a range of innovative programs within PSP to help clients address their barriers to employment.

Fishing Program

'More people in Australia watch friends than have them' source:
Wellness Conference, DHS 2003.

The fishing group was established in 2001 in response to the requests from a strong Bosnian contingent of PSP participants. The Bosnian clients presented with barriers to employment and social participation including Post Traumatic Stress Disorder, Anxiety, Depression and

Social Isolation / Alienation. While most experienced difficulty communicating as they were of a culturally and linguistic diverse background, they identified that they shared a common experience, and passion for fishing. So a Fishing Club was developed. The group originally met on a monthly basis to discuss fishing strategies and to organise monthly fishing expeditions. The Brotherhood of St Laurence PSP originally funded the first fishing day trip and participants spent the day fishing in Port Phillip Bay. The ongoing running of the group was not possible due to limited PSP funds - it fell outside of the program budget. In 2002 the Group applied for and received a grant from the Department of Natural Resources to host a three day fishing camp in Halls Gap. The Department organised for the program to be delivered by members from Angling Clubs from around Melbourne. Five fishermen volunteered their time and developed and implemented training in fly fishing for the camp participants. The group has also been successful in securing another grant from the Department of Sport and Recreation for this year's camp to Metung. The results from the camp were outstanding. Along with a chance to relax, clients developed skills and had an opportunity to participate in a group social setting. There were also other positive experiences from the camp that were informally noted by the participants Case Managers. These include an increase in attendance at appointments, participation in training and employment and increases in self confidence.

Healthy Exercise and Wellness Program

The Healthy Exercise and Wellness Program was developed in response to the clients requests on an annual needs analysis. The annual needs analysis is a three-pronged approach, involving a survey that is mailed to clients every six months asking them to identify areas that they would like training in, client focus groups and staff consultation. The analysis targets all clients of the Personal Support Programme, all of which are long-term unemployed. The Healthy Exercise and Wellness Program was highlighted as one of the primary activities that clients wished us to facilitate in the coming year. The group was developed in consultation with a fitness consultant (who volunteered his time) and it was aimed to increase the fitness level of participants in a safe, caring and supported environment. The group also provided the opportunity to help alleviate social isolation, increase social skills and build self-esteem. The program commenced in June 2003 for a duration of 10 weeks and was attended by participants from several Personal Support Programme providers. The group was facilitated by a fitness consultant and it included a variety of stretching, body weight circuit exercises and games.

The feedback from the group was very rewarding. All clients indicated that they found the group "very beneficial" and "extremely enjoyable". Social isolation is a barrier that appears to be common among long-term unemployed PSP participants. The group provided the opportunity to for clients to expand their social skills in an informal setting while also facilitating an increase in the client's social network. Several clients have remained friends since the program and they now meet on a regular basis for a social and walking group.

Work Readiness Program

'There is nothing good or bad, but thinking makes it so' Hamlet.

The Work Readiness Program was developed due to the lack of established innovative approaches to the facilitation of the long-term unemployed individual, experiencing mental health problems, to re-enter the workforce. The program was developed on a theoretical framework, namely cognitive behaviour therapy. This was because CBT has been shown to be an efficacious intervention and empirically validated treatment for the range of psychiatric

conditions that an unemployment client generally presents with (King and Ollendick, 1998). Some research had been undertaken on the effectiveness of the application of cognitive behaviour therapy to this client population, but with mixed results. For example, Creed, *et al* (1999) in their investigation titled *Improving mental health status and coping abilities for long-term unemployed youth using cognitive behaviour therapy based training interventions,* revealed that pre-employment training programs that are founded on a CBT framework can improve levels of well-being such as self-esteem, positive affect (such feelings of well-being) and coping skills short term and that these improvements can be maintained through to the longer term, in this case, four months after training completion. Behavioural plasticity effects were also evidenced. The disappointing finding of the study was that when employment status was measured for both the control and experimental group, it was found the control group were marginally more successful in obtaining work than the group who received the cognitive behaviour therapy training. It appeared that while CBT was instrumental in the promotion of well-being for clients, it did not really assist with the minimisation of psychiatric distress, as measured by the General Health Questionnaire – 12 (Goldberg, 1978). When we look to explain these findings, we discover that the training was conducted over 5 hours a day, over three (possibly consecutive) days.

The outcome of this research was similar to that of Harris *et al* (2002) who also identified behavioural plasticity effects. Both the intervention and comparison groups in the investigation reported psychological improvements after completing the CBT training, and improvements in the hopelessness and optimism variables were greater for the comparison group, as predicted. However, when the researchers explored the effects of the intervention on the variable of employment status, it was discovered that while some participants from both groups gained employment, the difference was not great enough to achieve statistical significance. The researchers explained the finding in terms of the high level of disadvantage of the clients, the value of motivation to change as a precursor to goal attainment and that opportunities for one-to-one discussions during the group were limited. Again, the training provided in this investigation was conducted in 11 hours over two (possibly consecutive) days.

Given that learning theory contributes to the foundations of CBT, it makes sense to re-visit some basic learning theory principles. The primary focus here should be massed versus spaced practice. Learning theory states that massed practice is helpful when you have an amount of time to learn a lot of information. The best example is cramming for an exam – we cram the night before, attend the exam, and when we exit the examination hall, all of the information we learned the night before seems to have disappeared. Learning theory recommends spaced practice for the acquisition of information that we may need to store and retrieve over the long-term. An example of this might be attending a night class to learn a second language, and the night class is one or two nights per week over 16 weeks.

We would suggest that based on the previous discussion, a CBT training program that is conducted over possibly the same number of hours used by the previous researchers, yet spread out over a greater period of time may improve employment related outcomes for participants. This would give participants time to consolidate information.

This conclusion formed the hypothesis and impetus for the current investigation of the Work Readiness Program. The WRP is conducted over 3 hours, once per week for 7 weeks. Pre, post and follow assessments are taken in order to evaluate the efficacy of the program in terms of improving coping skills, well-being and employment outcomes for participants. The evaluation will conclude in May 2004 and we would be happy to forward a copy of the final report to people who are interested.

In conclusion, the opportunities for innovation and collaboration in the development, delivery and evaluation of employment strategies for the long-term unemployed are limited only by our imagination. Look to the literature, look to your community, find the gap and work together to address it.

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