4

Government and other service providers

We have moved away from thinking about tackling mental health as a health problem to thinking of it as a whole-of-government problem.[1]

...a cross-government, cross-sectoral approach is now well-recognised to much better support people with a mental illness to achieve a whole variety of goals and to participate more fully in the community.[2]

...consumers who are working use services less because they keep themselves well. They are motivated and they are busy.[3]

We have gone through changes and changes. We are a tired industry. We want to go back and focus on the people we are supposed to be working with and I think that is really getting lost and I think that makes all the difference in our outcomes.[4]

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1 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, *Committee Hansard*, 9 August 2011, p. 1.

2 Ms Bronwyn Hendry, Director, Mental Health Services, Department of Health, NT Government, *Committee Hansard*, 17 October 2011, p. 24.

3 Mr Todd Bamford, Team Leader, Transitional Care and Early Psychosis, and Noarlunga Emergency Mental Health Services, Southern Mental Health, Adelaide Health Service, South Australia, *Committee Hansard*, 7 June 2011, p. 22.

4 Mrs Melissa Williams, Manager, Gold Coast Employment Services, *Committee Hansard*, 8 August 2011, p.13.

Setting the scene: Commonwealth, state and territory responsibilities

4.1 In Australia, states and territories are responsible for the service delivery of health and education. This chapter will focus primarily on what the Commonwealth Government can do to encourage education, training and workforce participation of people with mental ill-health because the Committee can only effectively make recommendations to the federal government. States and territories have their own approaches and programs through their respective departments of health and community services, education, employment and training.

4.2 Responsibility for the national mental health and welfare reforms, the building the future workforce agenda, and the budgetary allocations that go with these (outlined in chapter one) are shared across several Commonwealth departments and agencies. These issues are no longer simply confined to the health and employment portfolios.

4.3 When considering the key issues raised by stakeholders in respect of government and other service providers, it is useful to outline the main department and agency players at the federal level, to sketch out their portfolio and program interests, and the various reviews and reforms they are undertaking.

4.4 The chapter will also draw on examples of best practice from the states and territories that participated in the inquiry, and focus on how all government instrumentalities including those of the Commonwealth, together with contracted service providers, can help people with a mental illness participate more fully in the workforce.

4.5 The Committee places on the record its appreciation of the participation in the inquiry of government departments from the following states and territories: South Australia, Queensland, Tasmania and the Northern Territory. This evidence has helped to build a picture of service delivery across the country.

Commonwealth Government

DEEWR, FaHCSIA and DoHA

4.6 The three Commonwealth Government departments responsible for the policy areas directly relevant to the topic of mental health and workforce participation are:

- the Department of Education, Employment and Workforce Relations (DEEWR), responsible for national education and employment policy as well as income support policy for working age payments;
- the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), responsible for national policy on disability benefits and the implementation of a number of community based mental health initiatives and other targeted early intervention services; and
- the Department of Health and Ageing (DoHA), responsible for national policy and programs to improve mental health outcomes, including through targeted prevention, identification, early intervention and health care services.[5]

4.7 DEEWR is the lead agency for policy relating to disability and employment. However, the joint submission from the three departments refers to their contribution as part of a 'cross-portfolio package to drive fundamental system improvements'. Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR said that there is:

> a greater integration of services and joint management of these issues across government...A key feature [of the national plans and programs] is that they are crossing boundaries between health, education, family and workforce settings to address the critical issues that may impact on an individual's capacity to gain and maintain work. [6]

4.8 As mentioned in chapter one, the 2011-2012 budget contained a number of measures to increase the workforce participation of people with mental illnesses. A number of these are outlined in Section A of the joint submission. Key existing programs are also outlined at Appendix A of that document.[7]

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5 DEEWR, FaHCSIA and DoHA, *Submission 62,* p. 5.

6 Ms Buffington, DEEWR, *Committee Hansard*, 14 October 2011, pp. 1-2.

7 DEEWR, FaHCSIA and DoHA, *Submission 62,* p. 5 and pp. 10-41.

4.9 To summarise, recap, and provide a focus for this chapter, some of the relevant initiatives under 'national mental health reform' include:

- an increase in funding to headspace (Australia's National Youth Mental Health Foundation) to expand existing and establish new youth focused mental health services for young Australians aged 12-25 years, providing for 30 current, 10 developing and a further 50 headspace centres by 2014-2015;
- engaging states and territories to share the cost of an additional 12 Early Psychosis Prevention and Intervention Centres (EPPIC) – there are currently four- to offer a range of community care services to keep people at home and out of hospital -to assist some 11, 000 young Australians with or at risk of developing a psychosis to access education and employment opportunities;
- expanding community mental health services, including through the provision of 425 new personal helpers and mentors. The Personal Helpers and Mentors Scheme (PHaMS) gives practical one-on-one support to people with a severe mental illness for everyday living and setting and achieving educational and employment outcomes. As part of this expansion, up to 1200 people with mental illness on DSP will have access to PHaMs services; and
- funds towards building the capacity of employment service providers and Department of Human Services (DHS) staff (i.e. Centrelink) to assist people with mental illness to gain employment and better connect them to the appropriate services.[8]

4.10 In addition to these initiatives, the Government is encouraging workforce participation through:

- the introduction of participation requirements for DSP recipients under 35 who are identified as having some work capacity; amending the DSP to allow all recipients to work up to 30 hours a week continuously for 2 years and still remain eligible for a part-time pension;
- targeted Disability Employment Broker projects to link job seekers with a disability to employers; improving assessments for DSP claimants who are required to undergo a Job Capacity Assessment to ensure appropriate options for employment support and income are provided to them;
- 20 Job Services Australia demonstration pilots to serve up to 5000 highly disadvantaged job seekers – including coordinating complementary services and joint-case management;

8 DEEWR, FaHCSIA and DoHA, *Submission 62,* p. 5 and pp. 14-18.

- and an information campaign to promote the benefits of employing people who have experienced labour market disadvantage, such as those with mental illness and/or the very long-term unemployed.[9]

4.11 Under 'Building Australia's Future Workforce' there are programs to improve apprenticeship opportunities and to increase access to the language, literacy and numeracy program (LLNP).[10]

DHS (CRS Australia, Medicare and Centrelink)

4.12 The Department of Human Services (DHS) has carriage of service delivery policy and provides access to social, health and other payments and services. In 2011, the *Human Services Legislation Amendment Act 2011* integrated the services of CRS Australia, Medicare and Centrelink into the one department.[11] It is perhaps worth emphasising that DHS is responsible for service delivery, rather than the overarching policy framework for mental health and workforce participation, which is DEEWR's responsibility.

4.13 CRS Australia (formerly known as the Commonwealth Rehabilitation Service) offers disability employment and assessment services to people with a disability, injury or health condition, including people with a mental illness. In addition to disability management and employment services, CRS Australia delivers return-to -work programs and workplace rehabilitation and injury prevention services:[12]

> CRS is one of many disability management services providers...we provide services across Australia from 180 offices and also from a number of visiting services...We have a multidisciplinary workforce, including around 1,100 allied health professionals (e.g. rehabilitation counsellors, occupational therapists, social workers, psychologists, skilled at working with people with disabilities, including mental illness).[13]

4.14 Medicare describes its role as delivering health and payment programs to Australians. Those relevant to people with a mental illness include:

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9 DEEWR, FaHCSIA and DoHA, *Submission 62,* pp. 11-13.

10 DEEWR, FaHCSIA and DoHA, *Submission 62,* pp. 10-11.

11 DHS website, http://www.humanservices.gov.au/corporate/about-us/

12 CRS Australia website, http://www.crsaustralia.gov.au/list_of_our_services.htm

13 DHS, *Submission 43*, p. 4 and Ms Alison McCann, National Manager, CRS Australia, *Committee Hansard*, 4 November 2011, p. 18.

- the Mental Health Nurse Incentive Program which funds community based general practices, private psychiatric practices and other appropriate organisations to engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental health disorders; and
- administering payments for General Practitioner Mental Health Care items, which provide a structured framework for GPs to undertake early intervention, assessment and management of patients with mental disorders. It also provides referral pathways to clinical psychologists and allied mental health providers.[14]

4.15 Centrelink 'assists people to become self-sufficient and supports those in need.' The Centrelink program:

> delivers a range of payments and services for retirees, the unemployed, families, carers, parents, people with disabilities [including people with a mental illness], Indigenous Australians and people from diverse cultural and linguistic backgrounds, and provides services at times of major change.[15]

Service delivery mechanisms for job seekers with a mental illness – JSA and DES

4.16 In July 2009 new employment services were introduced to replace the previous national employment service called Job Network Services. Job Services Australia (JSA) is the Commonwealth Government's new national employment service:

> For job seekers, it provides personalised help to find and keep a job...For employers, JSA provides a free service to help find staff to meet their business needs.[16]

4.17 The Government (through DEEWR) contracts a mix of small, medium and large, for-profit and not-for-profit organisations to provide employment services in more than 2,000 locations across Australia.[17]

4.18 JSA providers work with job seekers to develop an Employment Pathway Plan, which maps out the training, work experience and additional assistance needed to help them people find sustainable employment.[18]

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14 DHS, *Submission 43,* p. 5.

15 Centrelink website, http://www.humanservices.gov.au/corporate/about-us/

16 DEEWR website, http://www.deewr.gov.au/Employment/JSA/Pages/default.aspx

17 DEEWR, JSA website, http://www.deewr.gov.au/employment/jsa/employmentservices/pages/serviceproviders.aspx

4.19 JSA providers are able to access an Employment Pathway Fund (EPF) to purchase assistance in line with the individual job seeker's needs including training courses, travel assistance, work equipment and specialist counselling services.[19]

4.20 JSA delivers employment services under four main service streams:

> The streams reflect the level of disadvantage faced by individual job seekers, with the least disadvantaged receiving services under Stream 1 and job seekers with severe disadvantage, including non-vocational barriers (like homelessness and drug and alcohol dependencies) serviced under Stream 4.[20]

4.21 Disability Employment Services (DES) was introduced in March 2010 and is a complementary specialist employment service for job seekers with a disability, injury or health condition. Ms Buffinton, Group Manager, Disability Employment Services Group, DEEWR elaborated on the services that DES offers:

> As part of the whole new Disability Employment Services there is a much broader package of support and information. One of the excellent services is the Job Access Service, which is first and foremost a telephone support service. In the last budget that was expanded to include people with mental illness backgrounds and psychologists who can recommend and give support in physical environments where people can get workplace modifications. An example with mental illness would be that, before somebody goes into an environment, mental health first aid courses are provided in the workplace so that people are open and welcoming to people with mental illness rather than it being something that is silent or that people feel awkward about and do not know how to cope with.[21]

4.22 Like JSA providers, DES providers are contracted by DEEWR to provide employment assistance, but specifically for people with a disability, including those with a mental illness. There are 1,900 DES providers across Australia.[22] The national network comprises public, community and private organisations.

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18 JSA website, http://jobsearch.gov.au/provider/pages/whichprovider.aspx

19 DEEWR, FaHCSIA and DoHA, *Submission 62*, pp. 28.

20 DEEWR, FaHCSIA and DoHA, *Submission 62*, p. 28.

21 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 13 October 2011, p. 2.

22 DEEWR website, http://www.deewr.gov.au/Employment/JSA/JobSeekerSupport/Pages/disability.aspx

4.23 DES consists of two components:

> **Disability Management Service (DMS)–** provides help to people with disability, injury or health condition who require the assistance of a disability employment service and are not expected to need long-term or regular support in the workplace; and
>
> **Employment Support Service (ESS)** – assists people with permanent disability who are likely to need regular long-term ongoing support in order to retain their job.[23]

4.24 Under DES all eligible job seekers are able to receive an individually tailored program of assistance from their DES provider to help them prepare for, find and keep a job. DES providers seek to overcome vocational and non-vocational barriers to employment for their clients and offer various education, training and skills development opportunities.[24] In addition to the Job Access Service described above, DES supports include the wage subsidy scheme and the supported wage system (these supports have already been outlined in some detail in chapter three).

New participation requirements for DSP recipients

4.25 As of 1 July 2012, new participation requirements will come into being for DSP recipients, under the age of 35 and classified as having some work capacity. DSP recipients who are assessed as able to work 8 or more hours a week will be required to attend regular participation interviews with Centrelink to get advice on the impact of employment on their benefit, and the programs and supports available to help them find and keep a job. DSP recipients may also volunteer to be referred to JSA or DES providers. DSP recipients classified as being able to work 15+ hours a week will be required to look for work and be connected to an employment services provider. [25]

4.26 The participation requirements for DSP recipients are determined according to someone's assessed work capacity, as below:

- 0-7 hours per week – job seekers are not required to look for work but can volunteer to connect with an employment services provider;
- 8-14 hours per week – job seekers are not required to look for work but can volunteer to connect with an employment

23 Australian Government, Australian JobSearch website, http://jobsearch.gov.au/provider/pages/whichprovider.aspx viewed 21 February 2012.

24 DEEWR, FaHCSIA and DoHA, *Submission 62*, pp. 25-26.

25 DEEWR et al, *Submission 62*, p.11.

services provider. To meet their participation requirements [these] job seekers with a partial capacity of 0-14 hours must attend a quarterly interview with Centrelink unless they are meeting requirements through paid work;

- 15-22 hours per week – job seekers will be required to look for work or undertake work of 15-22 hours per week and be connected to an employment services provider. They may be required to accept an offer of paid work, provided the work is suitable;
- 23-29 hours per week – job seekers will be required to look for work or undertake work of 23-29 hours per week and be connected with an employment services provider.[26]

Fear of losing DSP and health entitlements

4.27 The fear of losing access to the DSP and its associated benefits, including access to a pensioner card (which discounts the sometimes expensive medications for some mental illnesses) is a paramount concern that DSP recipients have about seeking and securing employment, beyond the now permissible 30 hours a week. Anglicare Tasmania summarised:

> A barrier to seeking paid employment is the risk people face of losing their DSP – and the fear of relapsing into an episode of mental illness without any income at all.
>
> It is a deterrent for people to do 20/30 or more hours employment as they lose their DSP, housing rental goes up to full market rental and there is not much extra money per week for their contribution.[27]

4.28 Mr Dale Campbell, Chief Executive Officer, Top End Association for Mental Health, TEAMHealth agreed:

> Many welfare recipients will find themselves in a situation where they are reluctant to accept more than a minimal amount of paid work for fear of losing benefits...In some cases they can be materially worse off through losing benefits such as free transport, rent assistance and the like, while at the same time incurring additional costs such as transport, work clothing and things of that nature.[28]

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26 DEEWR et al, *Submission 62*, p. 21. More information on participation requirements is available from the DHS website, http://www.humanservices.gov.au/corporate/publications-and-resources/budget/measures/disability-and-illness/ptf20a

27 Anglicare Tasmania, *Submission 69*, p. 9.

28 Mr Dale Campbell, CEO, Top End Association for Mental Health, TEAMHealth, *Committee Hansard*, 17 October 2011, p. 18.

4.29 The Welfare Rights Centre corroborated this sentiment:

> People with mental health issues...are insecure about engaging in the workforce due to the episodic nature of their condition. The DSP is a safe option, not least because it provides recipients with a Pensioner Concession Card that makes medications much more affordable.[29]

4.30 A DSP recipient described the predicament consumers face:

> I don't want to lose my Health Care Card when I earn too much money. Medication is very expensive.[30]

4.31 Mrs Melissa Williams, Manager, Gold Coast Employment Services also spoke to concerns families have for their loved ones about the prospect of unaffordable medication:

> Families are often very hesitant for their young person because they are on four or five medications and if they lose their DSP or their concession card they will jump from $5.50 a script to $35 a script and they may have six.[31]

4.32 Open Minds similarly observed that the fear of losing welfare entitlements and other health benefits are 'primary reasons why people on the DSP do not participate in training, education or employment.'[32]

4.33 The National Employment Services Association (NESA) referred to a DSP Pilot Project undertaken by NESA providers that confirmed people perceived changed arrangements to the DSP as a potential threat, and they felt daunted by the prospect of having to reapply for the DSP should they become unwell and unable to work again:

> The risk of not being eligible for DSP under changed arrangements was not generally high but seen as a major risk and deterrent to participation which was often fed by headlines about the Government getting tough on welfare.[33]

4.34 There certainly appears some confusion about the rules and requirements surrounding the DSP benefit, its associated health care card, the work hours permissible and participation requirements alike. On the allowable work hours issue, Ms Heywood from TEAMHealth stated:

29 Welfare Rights Centre, *Submission 10*, p. 7.

30 Name Witheld, *Submission 55*, p. 1.

31 Mrs Melissa Williams, Manager, Gold Coast Employment Service, *Committee Hansard,* 8 August 2011, p. 14.

32 Open Minds, *Submission 27*, p. 2

33 NESA, *Submission 41*, p.6.

> I think that is a key issue...it is about educating the community and people so they understand that process.[34]

4.35 NESA underscored how important it is to reassure recipients that a safety net exists should a job not work out and they will not be worse off for venturing into employment.[35]

4.36 Orygen Youth Health proposed increasing the safety net effect saying:

> Consideration should be given to easing return to the DSP over a period of time after employment is commenced...We suggest that consideration is given to preserving some of the benefits of the DSP such as concessions on transport and utility bills for a period after employment commences to ease the transition to employment.[36]

4.37 In fact, DSP recipients do not automatically lose their benefit and health care card once they get a job: rather, it is a sliding scale. Essentially, work can be trialled and someone's DSP status maintained for a period of two years. Ms Melissa Lond, National Manager, Mental Health, Disability and Carers, from DHS explained:

> We need to help people understand that they can test their workability and that there are a lot of mechanisms to support them to do that, but there are also safety nets if it does not turn out to be sustainable employment. There has been a provision in the DSP legislation, since the payment was introduced, for suspension rather than a cancellation of the pension if a person attempts to return to work. If for whatever reason, they are not able to maintain that employment within a two year period they can have their pension restored without needing to go through the full assessment procedure again.[37]

4.38 The Centrelink website alludes to the sliding scale:

> The number of hours you can work and still receive DSP varies according to when you were granted the pension. If you work more than your allowable hours per week the DSP will not immediately be cancelled, it will be suspended for two years. This means if you find your job too difficult because of your disability

34 Ms Melissa Heyward, Director, Client Services, Top End Association for Mental Health TEAM Health, *Committee Hansard*, 17 October 2011, p. 21.

35 NESA, *Submission 41*, p.6.

36 Orygen Youth Health Research Centre, *Submission 28*, p. 5.

37 Ms Melissa Lond, National Manager, Mental Health, Disability and Carers, DHS, *Committee Hansard,* 14 October 2011, p. 11.

> or you need to reduce your hours of work in those two years, you can access DSP again without the need to prove your eligibility. Access to your Pensioner Concession Card continues for 12 months from the date your DSP is suspended.[38]

4.39 The joint department submission stated that all DSP recipients will soon be allowed to work up to 30 hours per week (as of 1 July 2012) – up from the 15 hours a week that was previously allowed:

> DSP recipients granted on or after 11 May 2005 will be able to work up to 30 hours a week continuously for two years and remain eligible for part pension. This will allow recipients to maximise their working hours without the suspension of their DSP entitlement. DSP recipients will still be subject to the application of the income test. The purpose of this measure is to remove a disincentive for DSP recipients to participate in the workforce and address the inconsistent treatment of people granted DSP before or after May 2005. **Note: people granted DSP before 11 May 2005 are already allowed to work up to 30 hours a week and remain eligible for a part pension**.[39]

4.40 On the health care card issue, Ms Lawson of the Welfare Rights Centre said that people need to know that there is a low-income health care card available [as an alternative to the pension card, should clients not be eligible for that].[40] Ms Lawson suggested ways to disseminate that message:

> Centrelink could advertise it more or provide information to people who are leaving the DSP after a review or after a year in employment when their pension card runs out. That information could be sent to them to let them know about it. We also think there is a greater issue of education and training for the community sector and the public mental health sectors.[41]

4.41 The Committee agrees that a communications strategy that effectively conveys these messages to all stakeholders is important, and will examine this further on in the chapter.

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38 Centrelink website,

39 Joint department submission, *Submission 62*, p. 12.

40 Ms Georgina Lawson, Project and Research Officer, Welfare Rights Centre Inc, *Committee Hansard,* 9 August 2011, p. 26.

41 Ms Georgina Lawson, Project and Research Officer, Welfare Rights Centre Inc, *Committee Hansard,* 9 August 2011, p. 28.

4.42 The Committee notes an apparent widespread misunderstanding about or lack of knowledge by DSP recipients of the mechanisms available to help people to transition off the DSP into employment.

Complex unwieldy bureaucracy

4.43 Consumers, consumer advocacy groups and employment service providers repeatedly referred to the difficulties that consumers face navigating their way through a complex social welfare system. Consumers spoke of having to 'explain their story' time and time again to bureaucrats and suggested that employment and social services should be better integrated, with any changes to consumers' benefit or pension entitlements more effectively communicated to them.[42]

4.44 Ms Gail Middleton, Executive Director of Welfare Rights Centre described the Centrelink system as 'extremely complex':

> The eligibility criteria are just becoming quite unbearable. I have worked in this industry now for 25 years and we have gone from a chart telling us what a person is entitled to, to booklets.[43]

4.45 Ms Georgina Lawson, Project and Research Officer, Welfare Rights observed that changes to the pension rules, including the new participation requirements, are but one example of change that can confound consumers and service providers alike:

> If we look at those new rules, you now have new and old rules for people in terms of their participation requirements. You have got different requirements depending on the person's date of birth and, come 1 January, you are going to have new and old rules in relation to an impairment table that is used for your reviews. There is a lot more to it than that, so the general community, the general recipient and many Centrelink officers do not know, and cannot be expected to know, all that information that is governed within those five common pieces of legislation that they use to determine someone's eligibility and entitlements, plus all the other policies that are used. We have created a monster in terms of the social security system and we have not matched that with any

42 See for example Name withheld, *Submission 65,* pp. 3-7, Welfare Rights Centre (Qld), *Submission 10*, p. 8, and Dr Geoff Waghorn, *Submission 15,* p. 4 and *Submission 15.1*, p. 6.

43 Ms Gail Middleton, Executive Director, Welfare Rights Centre Inc, *Committee Hansard*, 9 August 2011, p. 25.

> safeguards or quality information which is targeted towards the recipients and those who actually work with our recipients.[44]

4.46 Ms Emma Cotterill, Acting Director, Social Support, Commonwealth Ombudsman, referred to a system that is experiencing a high level of flux, and the subsequent scope for causing confusion:

> ...with there being so many changes on the table [with DSP] possibly means that things like the threshold for the number of hours that you can work without losing your entitlement possibly gets lost in the mix. The fact that the impairment tables are sort of up for review, the fact that there are other issues around people who are under 35 now potentially being asked to engage in participation where they previously have not been when they only have an eight hour capacity, I think it all mixes together and creates a lot of uncertainty about, 'Well, yes I understand the 30-hour rule but what if I lose it under the impairment tables?' There are too many things to juggle potentially that mean people will get confused and might understand one message but not the others.[45]

4.47 Mr Adam Stankevicius, Senior Assistant Ombudsman, Commonwealth Ombudsman spoke to the complaints his office receives. These highlight the fact that benefit recipients are not always clear about their obligations, nor are the explanations proffered by Centrelink always helpful:

> I think there is a whole series of tapers and thresholds in the social security system which confuses a lot of people. It happens in the youth allowance area as well as the DSP area and parenting areas where people are unsure about what threshold they meet and, if they go over the threshold...periodically, and they come back what impact does that have? We see a lot of complaints...they come to us because they have tried to go to Centrelink to get an explanation as to how it arose. The explanation is incredibly complex....and the response back from Centrelink has not made much sense.[46]

4.48 The Ombudsman also referred to Centrelink's correspondence as being problematic:

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44 Ms Georgina Lawson, Project and Research Officer, Welfare Rights Centre Inc, *Committee Hansard*, 9 August 2011, p. 29.

45 Ms Emma Cotterill, Acting Director, Social Support, Commonwealth Ombudsman, *Committee Hansard*, 14 October 2011, p. 32.

46 Mr Adam Stankevicious, Senior Assistant Ombudsman, Commonwealth Ombudsman, *Committee Hansard*, 14 October 2011, p. 31.

> They are usually quite good if they are about a single issue but once they are going to two or three issues they become a mish-mash because they are all automatically generated rather than individually generated.[47]

4.49 Mrs Hildred Kivelitz, Mental Health Coordinator, Carers, NT, described bureaucratic hurdles and the ensuing anxiety and stress that her clients experience when attempting to navigate the systems of Centrelink, service providers and other agencies. She relayed one man's story:

> Every time he received a letter from Centrelink his anxiety increased to a level of nausea and feeling physically paralysed. [48]

4.50 Ms Cherie Jolly, delegate of member organisation, Uniting Care Wesley Port Adelaide, Disability Employment Australia pointed to the toll that various assessment processes can place on people with a mental illness, especially when they need to be re-referred and reclassified:

> ...inaccuracy of referrals...puts people back through a system. They end up going back to Centrelink in stream 3 or 4, come back to us and fall out the system very disillusioned.[49]

4.51 Mrs Melissa Williams, Manager, Gold Coast Employment Services raised the issues of an increasing administrative burden on her staff of ever new guidelines, the difficulties of trying to always connect with the right person at Centrelink, and systems compatibility:

> Do you know where my training dollar goes now? On red tape – how to use this computer system, how we do that. It is not going on : how do we support this person with this diagnosis? It has just grown and grown. I am losing staff. I have just had a resignation today from somebody that basically just got to to the starting point, and they have just said, 'I love the job but I do not want all that.' So it is starting to impact.[50]

> You spend half your life looking up guidelines and cross-referencing. I guess it is an administrative burden on Centrelink and the department but trying to even find the right person you

47 Mr Adam Stankevicious, Senior Assistant Ombudsman, Commonwealth Ombudsman, *Committee Hansard*, 14 October 2011, p. 32.

48 Ms Hildrud Kivelitz, Mental Health Coordinator, Carers NT, *Committee Hansard,* 17 October 2011, p. 11.

49 Ms Cherie Jolly, delegate of member organisation, Uniting Care Wesley Port Adelaide, Disability Employment Australia, *Committee Hansard*, 13 October 2011, p. 8.

50 Mrs Melissa Williams, Manager, Gold Coast Employment Service, *Committee Hansard*, 8 August 2011, p. 12.

> are supposed to access is a nightmare due to the protocols on who to ring for help. It all takes my workers away. Because we cannot link the online diary that we have to use with our Outlook diaries, they are running two diaries all the time.[51]

4.52 Ms Buffinton from DEEWR acknowledged the issues regarding systems incompatibility, but countered:

> Over time, out IT systems will work better so we can flag if somebody has a concern. Service delivery will perform more broadly a wrap-around service. In the past we have had very different systems, but as we get better, if there is either somebody from the government or one of the employment services who has a concern, we will be able to flag concerns.[52]

4.53 As the next few sections will attest, the Committee can certainly appreciate how difficult it is for an outsider to get a handle on how all the elements of the employment and social services systems work and fit together. This could be even more difficult for someone with a vulnerability, including suffering from a mental illness.

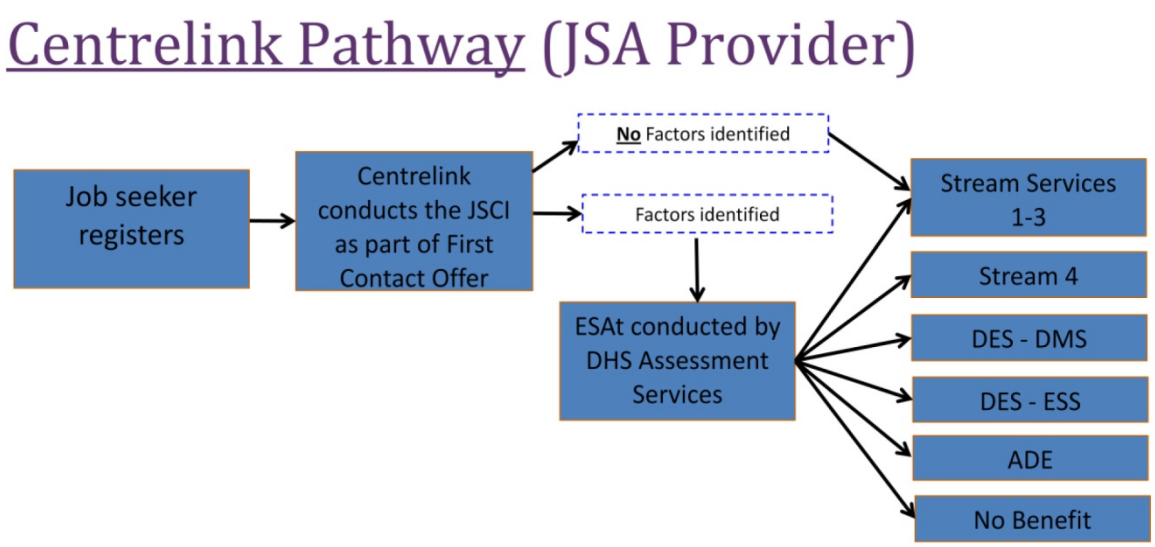
51 Mrs Melissa Williams, Manager, Gold Coast Employment Service, *Committee Hansard*, 8 August 2011, p. 14.

52 Ms Fiona Buffinton, Group Manager, Specialist Employment Services, DEEWR, *Committee Hansard*, 14 October 2011, p. 4.

Assessment and referral pathways

4.54 Figure 4.0 below shows how a job seeker is processed: assessed and referred on to generalist (streams 1 through 4 of JSA) or specialist employment services (DES).

Figure 4.0 Centrelink pathway (JSA Provider)



Source *DEEWR presentation on job seeker registration and assessment*

NB *ADE = Australian Disability Enterprises*

No benefit = someone who is assessed as having 0-7 hours work capacity and therefore not required to look for work.

4.55 The first assessment tool that someone encounters when registering as a job seeker with Centrelink is the Job Seeker Classification Instrument.

Job Seeker Classification Instrument

4.56 DEEWR is responsible for the administration of the Job Seeker Classification Instrument (JSCI). DEEWR describes the JSCI as:

> an objective measure of a job seeker's relative labour market disadvantage based on his/her individual circumstances. These individual circumstances are assessed using a job seeker's answers to the JSCI questionnaire plus other information known to influence employment prospects.

> The JSCI is designed to identify job seekers who, because of their individual circumstances, are likely to become long-term job seekers.[53]

4.57 Centrelink describes the JSCI as the tool they use to determine what employment assistance a person is eligible for. The JSCI consists of:

> a series of questions aimed at identifying what barriers you face entering the workforce. The JSCI is not intended to provide an individual assessment of your needs.[54]

4.58 DEEWR says that the JSCI determines the stream of services a job seeker is eligible for and/or whether further assessment is required though the completion of an employment service assessment:

> The key components of the JSCI are the factors (including sub-factors), questions, score and identification of the possible need for Employment Services Assessment (ESAt).
>
> The JSCI process involves collecting information about the factors using questions and other information derived from existing administrative data on the job seeker, to calculate a score used to determine a job seeker's eligibility for Streams 1, 2 or 3.
>
> Through specific responses to JSCI questions, the JSCI process may also identify the need for further assessment through an ESAt. The job seeker's eligibility for Stream 4 or DES is determined by the outcome of the ESAt.
>
> Where the ESAt recommendation is for Stream 1 to 3, the outcome of the ESAt finalises the JSCI score and determines eligibility for the appropriate Stream.[55]

Employment Service Assessments and Job Capacity Assessments

4.59 If a client is considered to require further assessment (that is they are not automatically allocated to streams one through three) they undertake an Employment Services Assessment (ESA or ESat):

> An Employment Services Assessment is conducted for disadvantaged job seekers identified as requiring further assessment of the impact of barriers on their capacity to participate in work or employment services.

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53 DEEWR website, http://www.deewr.gov.au/Employment/JSCI/Pages/overview.aspx

54 Centrelink website, http://www.centrelink.gov.au/internet/internet.nsf/services/jsci.htm

55 DEER website, http://www.deewr.gov.au/Employment/JSCI/Pages/JSCI.aspx

There will be two types of ESAts from 1 July 2011. These are

- Medical condition ESAt – An assessment of the job seeker's circumstances to determine work capacity and the most appropriate employment service, where one or more medical conditions are identified. ESAts are similar to the previous Job Capacity Assessments (JCAs) for potentially highly disadvantaged job seekers with disability, injury or illness. In a Medical condition ESAt the assessor must rely on the available medical evidence; and
- Non-medical condition ESAt – An assessment of the job seeker's circumstances that determines the most appropriate employment service, where no medical condition is identified — for example, a young person at serious risk of homelessness. A non–medical condition ESAt is normally less complex than an ESAt for a job seeker with disability, injury or illness, and will be streamlined to meet the individual's needs.

Wherever feasible, an ESAt will be conducted through a face to face interview. Where a face to face assessment is impractical for the job seeker (for example, due to geographic isolation or extreme weather conditions) or the job seeker has a medical condition or barrier which restricts them from attending a face to face interview, a video or phone assessment will be arranged.[56]

Eligibility for Stream 4 and Disability Employment Services (DES) is determined through an ESAt (for job seekers) or a JCA (for customers making claims for the Disability Support Pension).[57]

4.60 It appears that someone applying to go on the DSP must undertake a Job Capacity Assessment (JCA), rather than an ESat. Yet, a different part of the DEEWR website says that the Job Capacity Assessment program ceased on 30 June 2011.[58]

4.61 The Centrelink website states that it, or an employment service provider, will refer you for a JCA if you are applying for, or are on already on the DSP.[59]

4.62 The FaHCSIA website confirms:

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56 DEEWR website, http://www.deewr.gov.au/Employment/Programs/Pages/ESAt.aspx

57 DEEWR website, Job Seeker Classification Instrument, http://www.deewr.gov.au/Employment/JSCI/Pages/JSCI.aspx

58 DEEWR website, http://www.deewr.gov.au/employment/programs/jca/Pages/default.aspx

59 Centrelink website, http://www.centrelink.gov.au/internet/internet.nsf/vLanguageFilestoreByCodes/mcjca2100_0907_en/$File/mcjca2100_0907en.pdf

> A JCA is a comprehensive assessment of an individual's level of functional impairment and work capacity, usually conducted to determine qualification for DSP. The assessment identifies a person's:
>
> ⇒ level of functional impairment resulting from any permanent medical conditions,
>
> ⇒ current and future work capacity (in hour bandwidths), and
>
> ⇒ barriers to finding and maintaining employment and any interventions/assistance that may be required to help improve their current work capacity.
>
> A JCA can result in referral of a person to employment or support services that meet their individual needs, including JSA providers and DES providers.
>
> As part of the assessment process, assessors have access to relevant available information about the person, including current and past medical/disability details, and prior participation and employment history. Assessors can also liaise with treating doctors and other relevant health professionals as required.
>
> The JCA report is used by Centrelink to inform decisions on income support and participation requirements if applicable. A copy of the JCA report (not including impairment information) is also made available to the person's employment services provider.
>
> Generally, a JCA will remain current and valid for 2 years unless there is a significant change to a person's circumstances that affects their level of functional impairment and work capacity.[60]

4.63 The DEEWR website indicates that employment service providers can refer Stream 4 or DES job seekers for an ESAt in the event of any significant changes to that job seeker's circumstances that affects their work capacity/and or employment assistance needs.[61]

4.64 Ms Buffinton from DEEWR clarified:

> **ESA are the general assessment for employment. Those with a more complex case or those potentially for disability pension requirements are still known as job capacity assessments. These are carried out by allied health professionals.**[62]

60 FaHCSIA website, http://www.fahcsia.gov.au/guides_acts/ssg/ssguide-1/ssguide-1.1/ssguide-1.1.j/ssguide-1.1.j.10.html

61 DEEWR website, http://www.deewr.gov.au/Employment/Programs/Pages/ESAt.aspx

62 DEEWR website, http://www.deewr.gov.au/Employment/Programs/Pages/ESAt.aspx

4.65 Ms Buffinton alluded to changes that have brought employment services assessment back into to her department, DEEWR:

> Prior to 1 July [2011] there was a range of 18 providers. About 60 per cent of them were carried out by Centrelink and CRS Australia with the remainder carried out by another 16 providers, one government and the remainder private.[63]

4.66 The DEEWR website says:

> All ESAts are [now] conducted by qualified health and allied health professionals, such as a Psychologists and Registered Nurses employed by a single Government Provider under the Department of Human Services portfolio.[64]

4.67 Ms Buffinton emphasised that both JCA and ESAts are intended to build up a comprehensive picture of the person and their personal situation:

> The JCA or an ESA is not there as a diagnostic tool. It is there to work with a diagnosis that has come through from a health professional like a psychiatrist. These are trained allied health professionals. It is to see what the diagnosis is, but they are also trained in a much more holistic engagement of the person. Firstly, they are not doing a point in time of how a person appears at that moment in time during the discussion. They are taking a whole range of information [into account].[65]

Referral to DES

4.68 Figure 4.1 below shows how, following a job capacity assessment, clients are referred to or back to Centrelink (depending on whether they enter the system at a DES provider or Centrelink office level– most will enter via Centrelink), and are then referred on to a DES provider.

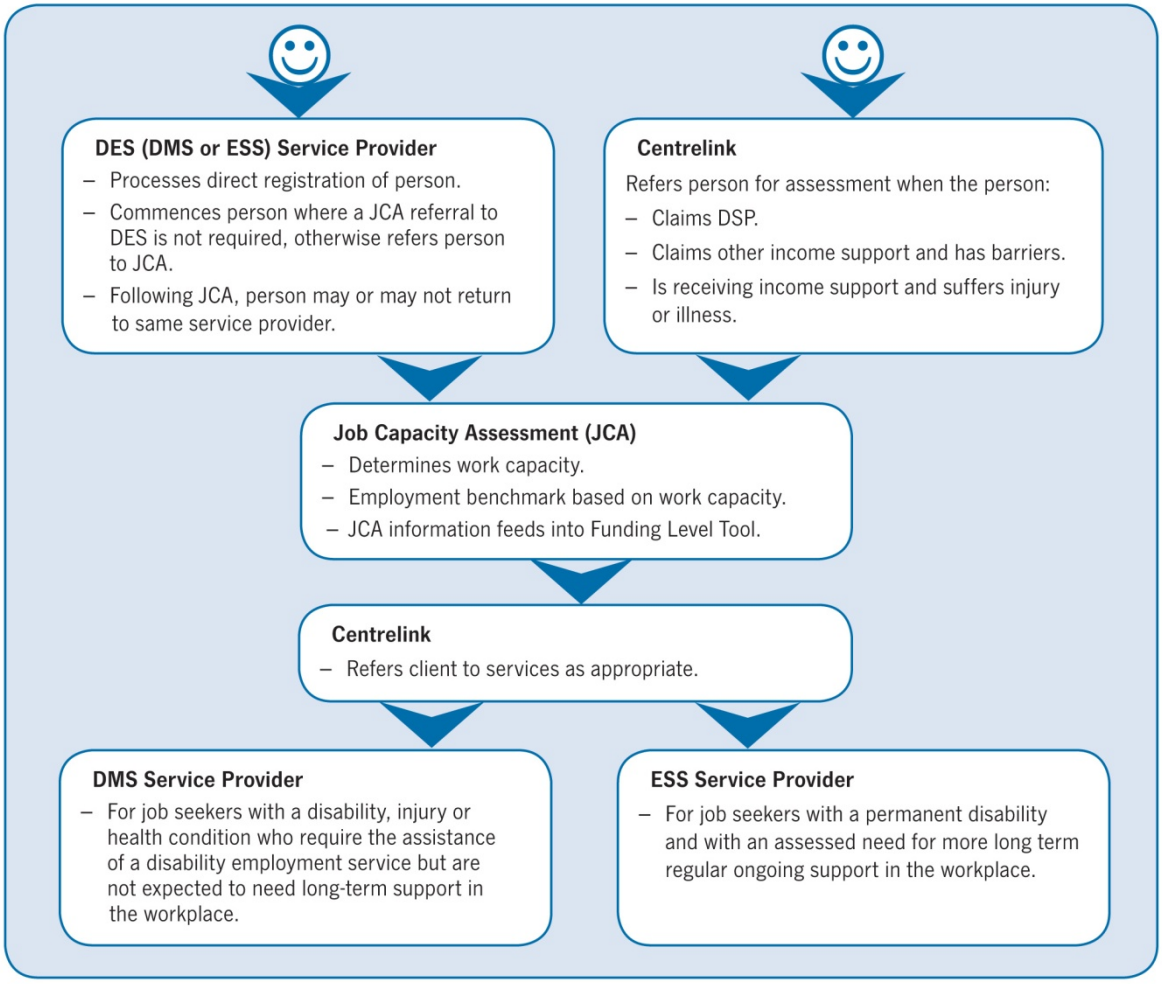
62 Ms Buffinton, DEEWR, *Committee Hansard*, 14 October 2011, p. 3.

63 Ms Buffinton, DEEWR, *Committee Hansard*, 14 October 2011, p. 3.

64 DEEWR website, http://www.deewr.gov.au/Employment/Programs/Pages/ESAt.aspx

65 Ms Buffinton, DEEWR, *Committee Hansard*, 14 October 2011, p. 3.

Figure 4.1 Pathways to DES



Source *Evaluation of Disability Employment Services Interim Report, Reissue March 2012*

Impairment Tables

4.69 There is another form of assessment that anyone applying for or on the DSP is subject to.

4.70 Eligibility for the DSP pension, in the first instance, is determined according to an impairment rating:

> As part of the qualification for DSP a person must have one or more physical, intellectual or psychiatric impairments that attract a total impairment rating of 20 points or more under the Impairment Tables.
>
> **Note:** A claimant who has a total impairment rating of at least 20 points, must also have a CITW (continuing inability to work) to qualify for DSP.
>
> Explanation: Some claimants may have an impairment rating of at least 20 points but do not have a CITW because they can work full-time where wages are at or below the minimum working wage or be re-skilled for such work within 2 years. [66]

4.71 The impairment rating has nothing to do with the referral process to employment services per se, but is mentioned here in the assessment section as another form of assessment a job seeker with a mental illness must undertake. Like other elements of the system, it too has been the subject of a recent review.

4.72 As a result, the tables have been modernised:

> Last year the Australian Government commissioned an expert Advisory Committee to review the tables and recommend revisions that are up to date with contemporary medical and rehabilitative practices...The report finds that the current Impairment Tables are out of date and contain anomalies and inconsistencies which have distorted the assessment process.
>
> The Advisory Committee has developed revised impairment tables...that, for the first time, include explicit guidelines about the impact of episodic or fluctuating conditions, such as some mental health conditions. This will help ensure assessments of eligibility for DSP for people with episodic conditions are fairer and more consistent than under the current tables.[67]

66 FaHCSIA website, Guide to Social Security Law, Version 1.186, released 30 April 2012, http://www.fahcsia.gov.au/guides_acts/ssg/ssguide-3/ssguide-3.6/ssguide-3.6.2/ssguide-3.6.2.100.html

67 DEEWR, FaHCSIA and DOHA, *Submission 62*, p. 22.

4.73 FaHCSIA says that the Tables now support a greater focus on functional ability and what people can do, rather than what they cannot do:

> For example, under the old Tables, ratings for some conditions such as back conditions were based on loss of movement. Under the revised Tables, ratings will be based on what the back condition prevents a person from doing.
>
> The old Impairment Tables contained anomalies and inconsistencies which distorted the assessment process.
>
> For example, under the old Tables when hearing impairment was assessed, a person with a hearing aid was not required to wear it, but someone who was having their sight impairment assessed had to wear their glasses. Under the revised Tables, people will be assessed when using or wearing any aids or equipment that they have and usually use.[68]

Problems with assessment and referral processes

4.74 In addition to the issues raised earlier, namely confusion about the new DSP participation rules, and Centrelink and the employment services' inherent complexities, the following areas of assessment and referral procedures were identified as further inhibiting participation of users of services: delays in processing; inappropriate assessments; and the re-referral process.

Delays in processing

4.75 Orygen Youth Health referred to lengthy assessment processes, as 'the de-motivation period' for clients who present to employment agencies wanting a job. Orygen said that assessment processes must be truncated in order to better engage the job seeker:

> Clients have expressed frustration at the long period of assessment they must undergo before initiating job-seeking. This assessment period can be up to two months in which time no job searching is done.[69]
>
> this period must be substantially reduced to provide optimum support and encouragement to young people with mental illnesses

68 FaHCSIA website, http://www.fahcsia.gov.au/sa/disability/payments/Pages/faq_impairment_tables.aspx

69 Orygen Youth Health, *Submission 28*, p.3.

> in their job seeking...everything possible must be done to make the job searching process easy to access and quick to produce results.[70]

4.76 The *Evaluation of DES Interim Report- Reissue March 2012* acknowledges that assessment delays are an issue:

> Streamlined access is another area for attention. The key indicator, the number of days from referral to commencement shows that on average job seekers are taking longer to commence service than under the previous programs.[71]

4.77 Ms Buffinton from DEEWR pointed to some of the reasons for delays, including people not presenting with all the necessary information or documentation in order to progress their assessment process.[72]

4.78 She also suggested that specialist disability employment services, by their nature, are more time intensive:

> The whole notion of DES is that it might not be that the instant you arrive you immediately get a job placement: it is a matter of what the employment service can do to value add. They will look at the barriers-if you have homelessness issues, if you have anger management issues, if you have a whole range of issues – and how you deal with those things and support you to be job ready so that when you connect with the employer, you match up very well.[73]

4.79 Further, baseline work is often required, necessitating a stepping approach. She elaborated:

> When a person's assessment is made, because the disability employment services work on the basis that this could be up to two years support, we do not necessarily expect that when you come into the employment services in month one you are out getting employment.
>
> ...before you even start getting employment outcomes there is a lot of baseline work done with the person, particularly in the case of mental illness, so that when the assessment is given the assessment is the potential work capacity of this person with intervention.[74]

70 Orygen Youth Health, *Submission 28*, p.4.

71 DEEWR, Evaluation of DES Interim Report, Reissue March 2012, p. viii, http://www.deewr.gov.au/Employment/ResearchStatistics/ProgEval/Documents/DESEvaluationDESfinal.pdf

72 Ms Fiona Buffinton, DEEWR, *Committee Hansard*, Canberra, 14 October 2011, p. 3.

73 Ms Buffinton, Group Leader, Specialist Employment Services, DEEWR, *Committee Hansard*, 13 October 2011, p.2.

74 Ms Fiona Buffinton, DEEWR, *Committee Hansard*, Canberra, 14 October 2011, p. 4.

4.80 The Committee is of the view that the assessment process should be expedited as quickly as possible with a view to engaging the job seeker as soon as practicably possible in the job search and job placement process or connecting them to further education and training.

4.81 To streamline the various assessment processes, DEEWR, Centrelink and employment services providers (JSA and DES) should work together to ensure that the assessment criteria for and requirements of job seekers with a mental illness are compatible and consistent across the services.

Recommendation 10

The Committee recommends that the Commonwealth Government work with employment service providers to streamline assessment processes for job seekers with a mental illness and ensure that the assessment criteria for and requirements of job seekers with a mental illness are compatible and consistent across the services.

Inappropriate assessments

4.82 Witnesses were critical of the JSCI and JCA processes insofar as they correctly identify, categorise and refer people on to the services most appropriate for them. Edge Employment Services in Western Australia said that:

> Job Capacity Assessments are not appropriately identifying and referring individuals with mental health issues to available services.[75]

4.83 Mr Lucas Mackey, a senior case manager from Workskills, provided a recent example where a client had not disclosed his full story to Centrelink, and presented to Workskills as a stream 2 job seeker, early school leaver, when he actually had a number of other vulnerabilities that should have been factored into his assessment [placing him into a higher stream level]. Mr Mackey elaborated:

> We are reliant on someone in a face-to-face meeting with Centrelink in the future picking up on that and then choosing further to question it.
>
> I know it has been freer in the past in the sense that job service providers have had an opportunity to refer back to Centrelink or to go to a job capacity assessor to have an assessment done. I am aware of the fact that organisations in the past have possibly

75 Edge Employment Services, *Submission 66*, p. 3.

> misused the instrument...I suppose a frustration from our point of view as an operational process is that all the organisations are tarred with the same brush as the organisation that abused the power...[76]

4.84 The NSW Consumer Advisory Group said individuals who are mentally unwell are not always qualifying for DSP because of inaccurate assessments. And, owing to their illness, they are not able to adhere to the requirements of the benefit they are put on instead, such as the Newstart allowance. This results in them receiving participation failures and experiencing periods of no payment from Centrelink.

4.85 One example they gave involved a mental health consumer who had a long-term alcohol addiction, which caused severe organ damage. They say his condition should have qualified him for DSP but he remained on Newstart allowance. His impairments had impacted on his ability to attend appointments with his JSA provider, he had received a participation failure and could incur an eight week payment cut off period. The consumer said of his own situation:

> I don't see the point of the entire system. If I get breached for eight weeks, I can't afford to pay my rent and then I will become homeless. If I am made homeless, I am going to be less likely to get a job than I already am. Plus while you are a breached Job Services gives you no assistance to look for work![77]

4.86 Disability Employment Australia (also known as ACE) emphasised that consumers with mental illness, especially significant psychiatric or psychotic illness can be a complex client group, with co-morbidities including substance abuse and homelessness and putting people into the wrong stream [or not on the DSP or into DES] means that providers are not funded to provide these people with the full suite of services that they may require:

> Funding level assessments are conducted via an independent IT based tool which collects non-subjective data from the JSCI and JCA report. Since the implementation of this methodology, feedback from the providers has indicated that clients with mental illness are trending towards the lowest funding level available.
>
> From ACE's perspective it is critical to ensure that the tool is as representative of the support needs of participants as possible- as

76 Mr Lucas Mackey, Senior Case Manager, Workskills Inc, *Committee Hansard*, 4 November 2011, p, 3.

77 NSW Consumers Advisory Group, *Submission 42*, p. 13.

> the level of funding is directly related to the amount of support that a provider is able to provide to a participant while still maintaining a financially viable service that is able to meet the needs of all participants. [78]

4.87 Some witnesses argued that part of the problem with the assessment and categorisation processes lies with the JSCI largely being conducted by telephone, rather than in person. The National Employment Services Association stated:

> The initial implementation of the Job Seeker Classification Instrument (JSCI) with job seekers is conducted on first contact with Centrelink and most often is conducted by phone interview.
>
> The industry has long contended that development of sufficient rapport and trust to elicit disclosure is best achieved in a face-to-face situation.[79]

4.88 Ms Helen Hudson from Workskills expressed similar frustrations:

> We find that quite often job seekers will come to us for their initial appointments and have been placed into a fairly low stream – stream 1 in a number of cases, or stream 2 or stream 3 – because that initial interview has been conducted over the phone.[80]

4.89 Mr Peter Ball, Service Leader, Department of Human Services, Tasmania Office explained how and why Centrelink had moved to provide job classification processes over the phone, rather than always via a face-to-face situation. He said this was something phased in over the last 18 months, and Tasmania had been part of the national trial. DEEWR and DHS believe the new model provides better services because:

> We could have more people who are better skilled available to more people over the phone.[81]

4.90 Moreover,

> My understanding is that DEEWR are comfortable with the phone-in service, otherwise I am sure they would have had robust conversations with Centrelink. In fact our ongoing processes are to work very closely with DEEWR as to how all the processes are going and how effective they are...I do not have responsibility for

78 Disability Employment Australia, *Submission 48*, pp. 7-8.

79 NESA, *Submission 41*, p. 7.

80 Ms Helen Hudson, Senior Case Manager, Workskills Inc., *Committee Hansard*, 4 November 2011, p. 1.

81 Mr Peter Ball, Service Leader, DHS, *Committee Hansard*, 4 November 2011, p. 12.

> the national management- my understanding is that DEEWR has worked with us nationally in that regard and are confident that the outcomes we achieve through the phone service are comparable to those that were achieved through the face-to-face service.[82]

4.91 DEEWR corroborated:

> in 2010 no significant difference was found in the consistency of Centrelink administered JSCIs, irrespective of whether the JSCI was completed at a face to face or telephone interview. Job seekers were allocated to the same service Stream between 90 to 94 per cent of occasions.[83]

Re-referral process

4.92 Concerns were raised regarding the ability to refer someone for reassessment if it appears they have not been placed in the right stream of employment service in the first place, or their circumstances are better identified at a later stage, or change, subsequent to their initial assessment.

4.93 JSA customers may initially be put in a general Stream 1 or 2 category because their illness is undiagnosed or undisclosed or they are well at the time of their initial assessment, however, owing to the episodic nature of their mental illness may later require assistance more in line with a Stream 3 or 4 level of vulnerability or a DES provider.

4.94 Ms Cherie Jolly, Delegate of member organisation, Uniting Care Wesley Post Adelaide, Disability Employment Australia pointed to the need for flexibility in the system to reclassify people, if necessary (although that too can cause problems):

> The flexibility of the program, starting with the job capacity assessments and the job seeker classification instrument, has a real impact...when people with a mental illness enter the Centrelink system they are generally at a point where they are really unwell. When they come to us, they are only partially through the recovery stage. They come to us with some stuff going on and they have their current and future benchmark hours...but the assessment itself should only be there to set criteria: they meet the criteria to come to us. Currently it is more about their funding level and what stream they go in and what their participation requirement is. That process brings an enormous amount of stress

82 Mr Peter Ball, Service Leader, DHS, Tasmania Office, *Committee Hansard*, 4 November 2011, p. 12.

83 DEEWR, Exhibit 41, JSCI Reviews Info.

> and pressure to bear on the individual, which often makes it difficult for us to engage. So flexibility around going back and being able to recall and reassess is one point we would like to highlight. That then brings inaccuracy of referrals and puts people back through a system. They end up going back to Centrelink in stream 3 or stream 4, come back to us, and fall out the system very disillusioned.[84]

4.95 Workskills reiterated difficulties they had experienced getting reassessments for their clients:

> If someone comes in exhibiting fairly significant symptoms of mental health issues and they are in stream 1, we can no longer refer them directly for a reassessment with Centrelink, which we used to be able to do...It is up to the job seeker to go to Centrelink and explain that they have particular problems and issues and request a further assessment or appointment with a social worker and so on.[85]

4.96 DEEWR indicated that employment service providers can refer clients back for reassessment. Ms Buffinton stated:

> On the rare occasions where a provider thinks that things may have not been disclosed, there are ways and means for the employment service to alert.
>
> It is rare but in more extreme cases they can refer for another assessment.[86]

4.97 Mr Alastair Bissland, Social Worker, DHS, Tasmanian Office said that it was his understanding that the inability to re-refer for streamed services review was 'nowadays no longer the case.'[87]

4.98 Ms Denise Frederick, Divisional Manager, Victoria/Tasmania, CRS Australia, alluded to the fact that it can take time for people to reveal and or realise the extent of their mental health condition, but the system can and does accommodate that:

> As a number of witnesses have identified this morning, sometimes it takes a little bit of time in the process as job seekers might reveal

84 Ms Cherie Jolly, Delegate of member organisation Uniting Care Wesley Port Adelaid, Disability Employment Australia, *Committee Hansard*, 13 October 2011, p. 7.

85 Ms Helen Hudson, Senior Case Manager, Workskills, *Committee Hansard*, 4 November 2011, p.1.

86 Ms Buffinton, *Committee Hansard*, 14 October 2011, p.3.

87 Mr Alistair Bissland, *Committee Hansard*, 4 November 2011, p. 12.

> further information, and we would work with them to obtain the appropriate medical information that would assist in getting them into the correct service...Most of the time we are the right place if the referral comes through, but if we are not then we need to take that forward. We would have interaction with the assessors. We do have sessions where we can talk to the assessor so that they really understand the service that we provide, because we think that is really important.[88]

4.99 Mr Niko Milec, Social Worker, DHS observed that re-assessment is an automatic part of the reconnection process when customers have participation failures:

> In the discussions we have with customers, mental health is a relatively common feature for those customers who were having significant difficulties engaging with their job service providers and engaging with their participation requirements...The JSCI is essentially reviewed every single time we have contact with a customer in relation to the participation report. Checking whether a customer is appropriately streamed is a critical part of that assessment. Certainly for social work, when we undertake comprehensive compliance assessments, which are an assessment that is undertaken before a decision is made about a serious failure, that would be almost mandatory.[89]

4.100 Mr Alistair Blissland, Social Worker, DHS agreed that the referral process can be problematic in identifying mental health issues when:

> Often we get referrals which are secondary or co-morbid issues. Those can be accommodation, drug and alcohol or domestic violence issues. Mental health is an underlying or latent issue.[90]

4.101 However, he noted that Centrelink is regularly in contact with external providers, including the employment services providers and they will respond to requests for additional assistance from service providers, including the reassessment of clients:

> on several occasions they have contacted us directly and said, 'we have a customer we are concerned about. They are presenting in

88 Ms Denise Frederick, Divisional Manager, Victoria/Tasmania, CRS Australia, *Committee Hansard,* 4 November 2011, p. 20.

89 Mr Niko Milec, Social Worker, DHS, Tasmania Office, *Committee Hansard*, 4 November 2011, p. 14.

90 Mr Alistair Bissland, Social Worker, Department of Human Services, Tasmanian Office, *Committee Hansard*, 4 November 2011, p. 13.

> an unusual way. They are manifesting depression, anxiety...Would you organise an appointment for them and any referrals and support?' which of course we do. That happens on a regular basis. The vast majority of referrals we get would be walk-ins or direct. Again, it would not necessarily be mental health as a presenting issue, but it would be a latent issue.
>
> Invariably the job service provider would ring us if there were any concerns [about a client's streaming for job services]. We would organise an appointment and in the course of the appointment we would do a brief mental health assessment. That may mean updating the JSCI, and, from there, organising another job capacity assessment.[91]

4.102 Mr Bissland cited a recent successful example of Centrelink working together with Workskills to re-stream a client with a mental illness:

> I had contact with Workskills directly when they rang up about a young chap that they believed was significantly depressed. He did not have a diagnosis and he did not have a GP and they sent him through to us. We did a brief assessment with him and it was fairly evident that he had symptoms of depression...so we did a written referral to a GP...He attended the appointment and got a medical certificate and doctor's report. We organised an assessment and from there he was streamed to a more appropriate provider.[92]

4.103 Mr Peter Ball, Service Leader, DHS advised further that:

> We do have regular meetings with Job Search providers and with DEEWR. In the case cited by Workskills, it sounds as though there has been a deficiency of some sort—perhaps a breakdown in communication there. But we do have in place those processes.[93]

4.104 DHS emphasised that the Commonwealth Government has sought to redress the problems with reassessments:

> The government has brought those assessment services back into government, delivered by the DHS with previous CRS and Centrelink staff. These are made up of allied health professionals and they cover a wide range of areas. Where a person has

91 Mr Alistair Bissland, Social Worker, Department of Human Services, Tasmanian Office, *Committee Hansard*, 4 November 2011, p. 13.

92 Mr Alistair Bissland, Social Worker, Department of Human Services, Tasmanian Office, *Committee Hansard*, 4 November 2011, p. 15.

93 Mr Peter Ball, DHS, Tasmanian Office, *Committee Hansard*, 4 November 2011, p. 15.

> information and evidence that requires a new assessment and they are in stream services, then they will approach a Centrelink office with that information and an appointment can be made for a stream services review. The assessment is made up on a job seeker face-to-face, where possible, and in the majority of cases, except if there are major barriers to that happening.[94]

4.105 DEEWR concurred:

> ...one of the things is making sure that the employment services get feedback if they have raised a query. We must make sure it is fed back whether we think there is a need for reassessments.[95]

DES performance

4.106 Ms Buffinton from DEEWR referred to a 2008 review of the disability employment services, and the job capacity assessments, then the gateway into the program. Ms Buffinton said:

> We developed the new Disability Employment Services learning from what was not right with the old system...That was developed in consultation with consumer groups, so the consumer groups were very actively involved – as were obviously employment providers, but also employers in the broader community.[96]

Uncapping of places

4.107 Ms Buffington stated that the 'single biggest element' of reform to DES has been the uncapping of places. Whereas, in the previous system, there was a waiting list and people could wait a year or more to get access, now people can get access as required.[97]

4.108 Dr Geoffrey Waghorn of the Queensland Centre for Mental Health Research endorsed this aspect of DES reform:

> There have been many positive enhancements to the program...such as uncapping program places and the introduction

94 Ms Hargreaves, National Manager, DHS, *Committee Hansard*, 4 November 2011, p. 15.

95 Ms Buffinton, *Committee Hansard*, 14 October 2011, p. 4.

96 Ms Buffinton, Group Manager, Specialist Employment Services, DEEWR, *Committee Hansard,* 13 October 2011, pp. 1-2.

97 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 13 October 2011, p. 2.

> of an independent ongoing assessment of support needs once people are in employment.[98]

4.109 National Disability Services agreed that the uncapping of places was an important move:

> The uncapping of the DES program in March 2010 provides an important precedent for this reform that would open pathways to employment and enhance flexibility and choice for employers and job seekers.[99]

4.110 Mr Todd Bamford, Team Leader, Transitional Care and Early Psychosis and Noarlunga Emergency Mental Health Services, Southern Mental Health, Adelaide Health Service, South Australia Health concurred and emphasised that previously, capping had been a significant barrier:

> when we consulted on the evidence based model, there was still a lot of capping, and that was raised just about everywhere as a barrier to being able to provide an evidence based service.[100]

4.111 The Committee learnt that subsequent to uncapping places, some agencies, such as UnitingCare Wesley Port Adelaide, had used that opportunity to expand into business areas they had not ventured into before. For instance, being part of the integrated service delivery model developed with Southern Mental Health (see later in this chapter for details).

Matching clients with DES providers

4.112 Despite the moves to uncap places, the Committee heard that some specialist service providers actually have a shortage of clients on their books, which they are not happy about. Mr Nick Bolto, the CEO of Ostara, a DES that focuses wholly on mental health, described how his service wants to help more people but is prohibited from so doing because clients are simply not being referred to their service:

> Most of our [114] sites are only half full or less than half full. We have talked to DEEWR and Centrelink. We have even had ministerial representation around the fact that, while government

98 Dr Geoffrey Waghorn RM, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, *Committee Hansard*, 9 August 2011, p. 10.

99 National Disability Services, *Submission 35*, p. 6.

100 Mr Todd Bamford, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 28.

> has funded specialist mental health services, people cannot get through the door. This is largely a policy issue of how job capacity assesses a client , interviews a client and then makes a decision about where the client will go. There is what they call the chocolate wheel. If the person makes no choice about the chocolate wheel spins and they get sent to a generalist provider. They have to ask for a specialist to get a service that meets their needs.[101]

4.113 Mr Bolto went on to explain that if a client does not explicitly 'opt in' to a specialist provider such as theirs, for reasons including the stigma of being sent off to 'disability' employment services, they will end up being 'randomly allocated to another [general] labour market support provider.'[102] Mr Bolto asserted that the problem is that:

> People do not know how to exercise their choice or why that choice is important.[103]

4.114 Ms Sharon Stuart, Branch Manager, Disadvantaged Job Seekers Branch, Specialist Employment Services Group, DEEWR refuted this, stating that the vast majority of people in DES do choose their own provider, after being appraised of the options available to them, and less than 10 percent of clients are part of any 'spinning chocolate wheel' system. Ms Stuart expanded:

> In fact over 90 percent of our clients have exercised choice...in some cases providers will find clients through the linkages they create in their own community or the client themselves will see some sort of promotion and come into a provider...People who come through the Centrelink gateway are given the options of the providers in their local area and asked to make a choice. If somebody has a primary psychiatric disability and there is a mental health specialist in that area, that particular provider will certainly show up on that list and be flagged as someone who works with that disability type, but the client will be given the choice of all of the other providers in that area. There are some circumstances where a provider's name may not show up on that list; that is where they have been sent a lot of referrals recently. They may temporarily drop off the list so that other providers can get some flow through.[104]

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101 Mr Nick Bolto, CEO, Ostara, *Committee Hansard*, 13 April 2012, p. 32.

102 Mr Nick Bolto, CEO, Ostara, *Committee Hansard*, 13 April 2012, p. 32.

103 Mr Nick Bolto, CEO, Ostara, *Committee Hansard*, 13 April 2012, p. 33.

104 Ms Sharon Stuart, Branch Manager, Disadvantaged Job Seekers Branch, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 13 October 2011, p. 6.

4.115 The Committee is of the view that time should be taken to explain the benefits of a specialist employment services provider to the client when Centrelink is going through all the options of providers in their area, and clients should be encouraged to make their own informed choice about the employment service provider they wish to try. This should not be immutable either, should things not work out with the first one they try.

Criticisms of DES performance

4.116 While Dr Waghorn, and others, support the uncapping of services, he offered an otherwise scathing assessment of the new DES' performance and proposed, in its place, an evidence based approach that centres on one-to-one assistance provided by a skilled employment specialist (this concept will be explored more fully throughout the rest of the chapter). He asserted:

> At the moment in Australia we have an increasing availability of ineffective services. The availability of services in Australia is no longer a barrier, except in remote locations. Australia now has a multibillion dollar disability employment industry, consisting of disability employment services contracted to DEEWR...the effectiveness has recently crashed. According to DEEWR's own interim evaluation released in July this year, specifically table 3.3 on page 31, only 10.6 percent of clients with a primary psychiatric disability at funding level two – the client group most relevant to our research – achieved 13 weeks of employment or an education pathway outcome in the nine-month period of March to December 2010. How can anybody say, 'wow' about a program that achieves 10.6 percent?
>
> The basic message is that it is the most populated subgroup of people with disabilities and it is the worst performing in the system The performance is now below what I would call a net zero effect.
>
> This evidence suggests that declining DES performance now represents the greatest barrier to employment for Australian community residents with severe mental health and psychiatric disability.
>
> The reasons for this declining performance...is a failure of the majority of DES providers to adopt the evidence based practices shown over the last 20 years to be the most effective in international trials for people with severe mental illness.

> It is that one-to-one arrangement that is done by a highly motivated, skilled, knowledgeable employment specialist that is an important part of the solution but the current DES providers do not do that. They are still operating along the lines of a JSA type service where it is all about volume, herding people through, coaching them in the office, giving them a list of things to do and sending them out in the big wide world and hoping some will make it.
>
> ...very good employment specialists do great deals with employers, back it up with reliable support and everybody wins through that. It is not easy but it can be done.[105]

4.117 According to Dr Waghorn the current funding structure acts as a disincentive to DES to find jobs for their clients. He asserted:

> DEEWR actually pay more for clients not to get a job than to get a job – over $15, 000 over two years for funding a level 2 client...all the service has to do is collect some referrals off a public mental health team, say all the right things, say they will do the work and rake in the service fees every quarter for having those clients on the books. They do not need to get a single person a job, and a service that has driven up their client load, to say, 50 clients, will collect $760, 000 fees over two years for one worker.[106]

4.118 Ms Buffinton's assessment of DES performance was contrary to Dr Waghorn's, namely that 'DES is working really well'.[107]

4.119 DEEWR has conducted an interim evaluation of the DES program. Of it, Ms Buffinton said:

> If you read the fine print on the interim evaluation, it was almost like a post-implementation check, which was just making sure that we got the program up and running. The new DES services started on 1 March 2010. The evaluation was done at the end of last year. So, at that time, when some people quoted some of those figures, the outcomes were quite narrow – as you would expect in a new program.[108]

105 Dr Geoffrey Waghorn RM, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, *Committee Hansard*, 9 August 2011, pp. 9-10.

106 Dr Geoffrey Waghorn RM, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, *Committee Hansard*, 9 August 2011, pp. 9-10.

107 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 13 October 2011, p. 2.

108 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 13 October 2011, p. 1.

4.120 The DEEWR website indicates that a further evaluation of the program is to be completed in the next financial year, 2012-2013.[109]

4.121 The Committee notes with interest Dr Waghorn's evidence regarding the perverse incentives that may exist in the present system, and believes his input should be sought in future evaluations of the DES program.

Disability Employment Services Performance Framework

4.122 Ms Buffinton went on to outline the Department's Disability Employment Services Performance Framework (the framework) and star ratings system which, in her words, assesses 'whether employment services are doing what we are asking of them and doing the best thing for the participant':

> The performance model measures the relative performance of providers. The framework is designed to drive performance and continuous improvement in the quality of delivery of services. We judge providers on efficiency, effectiveness and quality...We do this so disability consumers can see who is relatively high-performing and who is relatively low-performing. Twice a year we publish what we call the star ratings.[110]

4.123 The Committee recognises that the star ratings of all the disability employment services providers are published and made available on the DEEWR website.[111] And, if an agency specialises in mental health that is indicated on the star ratings spreadsheet. The accompanying explanatory information about how the star ratings are calculated should appear alongside the ratings (not on a separate web page as it presently does). A simple translation of what the star ratings might mean for the consumer regarding their choice of a provider should also be supplied on the website and relayed to clients in phone or face-to-face encounters with Centrelink.

4.124 The Committee is of the view that employment service providers that specialise in serving clients with a mental illness should be recognised and factored into the star-ratings system.

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109 DEEWR website, http://www.deewr.gov.au/employment/researchstatistics/progeval/pages/edesir.aspx

110 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, DEEWR, *Committee Hansard,* 13 October 2011, p. 4.

111 DEEWR website, http://www.deewr.gov.au/Employment/Programs/DES/PerfFramework/Pages/DESStarRatings.aspx

Sustainable employment and education outcomes

4.125 Ms Buffinton outlined how payments from DEEWR to DES providers for services rendered to people with a mental illness are increasingly weighted towards those which procure sustainable employment outcomes:

> Previously a lot of activity was rewarded whereas now we have become more outcomes oriented in how we pay disability employment services. A certain amount of fees are paid. Those service fees are relatively high because intervention for people with disability involves a lot of prep work before you are going to get outcomes. In the past there was a big focus on that activity and preparation. Now there is a balance between activity and preparation, but the emphasis is now on the outcome of actually helping somebody. After all, the whole aim of disability employment services is to help somebody get a sustainable-meaning ongoing-job in open employment. We have tried to bias the framework in the direction of those sorts of outcomes.[112]

4.126 DEEWR supplied a table setting out a range of DES service fees. These include job placement fees, 13 and 26 week outcome fees, quarterly ongoing support fees, and Job in Jeopardy Services Fees. There are a range of other reimbursements too, including ones that recognise an educational commencement or attainment. Further to Dr Waghorn's comments about the financial incentives to keep clients on the books rather than find them a job, and to provide some indication of the comparative monetary value of the one- off payments versus the ongoing payments: DES agencies receive $4, 400 for a 26 week full outcome for a DMS or ESS Funding Level 1 client. This increases to $7700 for an Employment Support Service Funding Level 2 client. Agencies receive $1450 for a 26 week pathway outcome for a DMS or ESS Funding Level 1 client, compared with $2,560 for an ESS Level 2. Ongoing support payments for DMS participants are $440 per instance. For other clients deemed to require moderate ongoing support, the agencies receive $1320 paid quarterly. This rises to $3300 per quarter for clients with high ongoing support needs. All fees command a premium for serving clients in remote areas.[113]

112 Ms Fiona Buffinton, Group Manager, Specialist Employment Services, *Committee Hansard*, 14 October 2011, p. 4.

113 DEEWR, *Submission 75*, p. 2.

4.127 DEEWR officials indicated that the 13 week and 26 week outcomes inform the star rating that an employment service gets, together with a range of other factors:

> The number of outcomes you get for that measure in comparison to your caseload counts towards 25 % of your star rating.[114]
>
> With the star ratings, disability type is one example of something we take into account. Others include the service requirements of participants, their higher-end needs, the labour market conditions of their particular location and so forth. We put that into a statistical regression which is used to adjust those factors. In the case of psychiatric illness, it is traditionally harder to achieve outcomes. So in the regression it gets a positive upweighting.[115]
>
> We basically rank all the providers on a scale.[116]

4.128 Dr Waghorn does not agree with the star rating or regression modelling used by DEEWR. He says to improve the efficiency of DES services, they need to be replaced:

> ...with a focus on a single outcome variable as the key performance indicator used to select or renew successful tenders. This key outcome needs to be the most challenging outcome, namely the proportion of clients that attain 26 weeks or more of accumulated employment during a particular contract. To assess this fairly, both diagnostic category and attrition also need to be accurately recorded, and employment in affiliated businesses to the employment system need must be either excluded as a non-competitive job or discounted in value through not being an optimal employment outcome.[117]

4.129 Employment service providers too had concerns with the outcomes payments and/or star ratings system. Ms Helen Hudson from Workskills Inc. stated:

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114 Mr Graham Harman, Director, Disability Employment Service Performance Section, Disadvantaged Job Seekers Branch, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 13 October 2011, p. 4.

115 Ms Fiona Buffinton, Group Manager, Specialist Employment Services Group, *Committee Hansard,* 13 April 2011, p. 4.

116 Mr Graham Harman, Director, Disability Employment Service Performance Section, Disadvantaged Job Seekers Branch, Specialist Employment Services Group, DEEWR, *Committee Hansard*, 13 October 2011, p. 4.

117 Dr Waghorn, *Submission 15*, p. 4.

> The way that contract is organised, there is no financial incentive for us to assist people with mental health issues to go that extra distance. People are providing that assistance but to a large extent that is unrecognised because there is no outcome, if you like, at the end of it. It is not getting a job for somebody. But if you assist people to get some help with their mental health issues that can be a huge positive step for many people.[118]

4.130 Similarly, Ms Cherie Jolly of Uniting Care Wesley Port Adelaide stressed that agencies do not always get rewarded for the work they put into preparing people for work:

> We get someone a job for three hours a week; that should be credited, but the time it takes us to get our performance up around that person involves putting the recovery stuff in place – the psychosocial stuff. So for speciality services there should be a lengthening of that performance. Our star rating at Port Adelaide is hideous because we maintain our values around preparing the person for sustainable employment.[119]

4.131 Orygen Youth Health expressed concerns that the JSA system focuses unduly on outcome payments, and does not incentivise educational outcomes for clients:

> In the course of our work we have met a number of people who were only a short distance away from completing various qualifications before they became unwell. When they engaged with JSA agencies they did not receive encouragement to return to and complete these courses. Instead they were placed in jobs that required no qualifications and encouraged to remain there until at least the period that corresponds with outcome payments was achieved....
>
> We believe very strongly that there needs to be incentives to encourage agencies to take a long-term view for the individual – to aim towards vocational recovery rather than job placement.[120]

4.132 Ms Phyllis Quensier, Service Integration Coordinator, Gold Coast Health Service, Queensland Health reiterated a point raised by Professor Butterworth in the first chapter that low quality jobs are probably not beneficial for people and self-defeating because:

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118 Ms Helen Hudson, Workskills Inc, *Committee Hansard*, 4 November 2011, p. 2.

119 Ms Cherie Jolly, Delegate of member organisation Uniting Care Wesley Port Adelaide, Disability Employment Australia, *Committee Hansard*, 13 October 2011, p.7.

120 Orygen Youth Health Research Centre, *Submission 18*, p. 8.

> That makes them very devalued to be seen as not worthy of anything better. Their motivation goes down, their stress levels increase and they can relapse due to the fact they are in a job that they feel they should not be in.[121]

4.133 Ms Buffinton defended the results so far:

> I will give you an indication of the current outcome rates because people are using historical figures in presentations to you. In terms of job placement under the Disability Management Service - 38% of those currently in the DES actually have a job placement, 26 per cent have hit a 13 week outcome and 18 per cent have hit a 26 week outcome. These figures are only going to build because we have only been running for 18 months. Obviously, if you came into the program in the last 6 months, you cannot possibly have a 26-week outcome. When we come back, those figures will build. Some of them are comparing against the old system, which had been running for a number of years and so had outcomes built up over quite a period of time. That is the efficiency and effectiveness side of it.
>
> On the issue of quality, all disability employment services are required to have certification that they meet the disability service standards.[122]

4.134 DEEWR indicated support for the new framework had been forthcoming from a wide range of stakeholders, and furthermore, it had been independently evaluated:

> We developed a technical reference group which had people from the former disability employment services, peak bodies, consumer groups and so forth. We looked at a whole range of different ways that we could judge performance. We then commissioned Access Economics to do some independent analysis of whether the model we had come up with was robust.[123]

4.135 The Committee is reluctant to recommend another review of the DES, when one was only conducted a few years ago and the new performance framework is expected to redress the shortcomings of the previous one.

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121 Ms Phyllis Quensier, Service Integration Coordinator, Gold Coast Health Service, Queensland Health, *Committee Hansard* , 8 August 2011, p. 22.

122 Ms Fiona Buffinton, Group Manager, Specialist Employment Services, *Committee Hansard*, 13 October 2011, p. 5.

123 Ms Fiona Buffinton, Group Manager, Specialist Employment Services, *Committee Hansard*, 13 October 2011, p. 4.

The Committee also notes that the Senate Standing References Committee on Education and Workplace Relations conducted an inquiry into the administration and purchasing of Disability Employment Services – Employment Support Services (DES-ESS) in 2011, making a number of recommendations including that DEEWR consider alternative purchasing models to the current one of a competitive tender process. The Government did not support this. [124]

4.136 Given that DES-ESS will continue to be funded through tender, and the Committee notes the current requirement that DES agencies meet disability service standards, the Committee does consider it essential that part of that tendering process require prospective employment service providers to be have some expertise in working with people with mental illnesses. This might form part of the star rating framework.

Recommendation 11

The Committee recommends that any future Disability Employment Services tender process require prospective disability employment services providers to provide evidence of expertise in working with people with mental illnesses.

4.137 The framework certainly warrants close ongoing attention, monitoring and evaluation, with input from interested stakeholders, to maintain their support. Presently, the star ratings appear to be heavily weighted towards quantitative outcomes (i.e. getting someone a job). This should not necessarily be at the expense of longer term qualitative outcomes, be these educational goals or career aspirations. In Professor Killackey's words, this may 'perhaps be in their long-term best interests.'[125]

124 See the government response to the Committee report, http://www.deewr.gov.au/Employment/Programs/DES/Documents/DESSenateInquiryResponse.pdf 12 February 2012.

125 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne, *Committee Hansard*, 24 March 2011, p. 7.

Recommendation 12

The Committee recommends that the Disability Employment Services Performance Framework be monitored and evaluated on a regular and ongoing basis. DEEWR should continue to consult with a technical reference group of stakeholders to ensure the framework's and star ratings' ongoing relevance and efficacy in achieving qualitative as well as quantitative outcomes for people with mental illnesses.

Improving communication and engagement

Disclosure and diagnosis

4.138 People are not always comfortable declaring their mental illness to government agencies or employment service providers. Sometimes they have an undiagnosed mental health condition. Either of these scenarios is a potential communication barrier to that person receiving appropriate services.

4.139 The National Employment Services Association (NESA) referred to the frustrations felt by employment service providers who find it difficult to connect their clients with the service they require because:

> ...the current classification framework is grossly inadequate to respond appropriately to people with low insight of their mental ill-health as it relies on self report and/or proof of diagnosis and impact to influence service classification.[126]

4.140 Ms Helen Hudson, Senior Case Manager, Workskills Inc. described the reluctance some job seekers with a mental illness have disclosing any information (about their illness or circumstances) to Centrelink for fear it might adversely influence their benefit entitlements, and the difficulties this poses to agencies like theirs, trying to help them:

> There are some job seekers with particular types of mental health issues – paranoia and anxiety in particular- where they feel that there is no way they are going to tell anyone from the government anything about their circumstances...We also have a number of clients who would need assistance through the DES and may have been recommended for those services as part of their assessment

126 NESA, *Submission 41*, p. 8.

> but refused to go to those appointments because of the stigma attached with the word' disability'...A lot of people will not admit that they have mental health problems and perhaps do not have any idea that they have mental health issues...[or] people may find it is okay to admit to depression which may be more socially acceptable to admit...rather than say that they are on medication for psychosis and things like that.[127]

4.141 Ms Nicole Cox, National Disability Coordination Officer, Edge Employment Solutions talked about some of the communication challenges presenting in the Kimberley region:

> Diagnosis and referrals are not occurring. ..They actually have to have informed consent by guardians, and in Indigenous communities there are often a lot of guardians...So it is a feat just for the psychologist to identify who legally they can be talking to...
>
> I sat in on a job capacity assessment by someone who came up from Perth....They asked the young lady whether she was Indigenous and she said 'no' and they ticked 'no' in the box. I had to explain about it. I asked questions like 'What is your country What is your language group?' She was able to answer. They also asked her if she had a disability and she said 'no'. You could tell she had a disability. She was sitting in a wheelchair. I asked her 'can you walk?'and she said 'no'. I would hate to think what would have happened if it had been an individual with a mental illness having that assessment. It is just so uncommon for an individual to identify.
>
> So there are huge issues around the job capacity assessments and the Centrelink assessments , and they all need to be modified to be culturally appropriate. [128]

4.142 Workskills referred to their Hobart site and communication challenges concerning new migrants:

> Our Hobart site observed that refugees and humanitarian entrants circumstances are not easy to document well through existing systems, e.g. experience of torture and trauma is not an available choice in JSCI questions (though post traumatic stress disorder is);

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127 Ms Helen Hudson, Senior Case Manager, Workskills Inc, *Committee Hansard*, 4 November 2011, p. 2.

128 Ms Nicole Cox, National Disability Coordination Officer, Edge Employment, *Committee Hansard*, 18 October 2011, p. 26.

> job seekers in these groups often distrust (perceived) government agencies; we, and they, put a lot of trust in their interpreters.[129]

4.143 Multicultural Mental Health Australia and the Transcultural Mental Health Centre referred to additional difficulties faced by people with a mental illness from cultural and linguistically diverse backgrounds, and a corresponding need for CALD-specific support workers:

> When people from CALD backgrounds with mental illness want to seek employment, some of the issues that they encounter are naturally language difficulties, and a lack of recognition of overseas qualifications, which often leads to them getting jobs below their qualifications or skills base. Some groups might not have an understanding of the recruitment process in Australia, how to write CVS or where to look for employment...there is also the interview process, imagine your English is not the best and you are exposed to that situation [and that]...there is a chance they will not be selected for interview because of the stigma attached to mental illness in the community.[130]
>
> Employing CALD-specific support workers and migrant resource agencies to run those PHaMs programs would be really good...
>
> I understand Centrelink runs community consultations from time to time to find out the needs of CALD consumers for courses and for welfare. Centrelink needs to run a lot more with a lot of different ethnic communities.[131]

4.144 The Commonwealth Ombudsman's *Falling through the Cracks* report identified greater consideration of the customer's barrier to communication and engagement as one of the four key areas for improvement for Centrelink and DEEWR alike.[132] Earlier parts of this chapter allude to the scope for miscommunication and disengagement, not least owing to a series of systemic and policy changes, from the introduction of a whole new employment services structure to streamlining the JCA process; new participation requirements; revised impairment tables and a new performance framework for the DES - to

129 Workskills, *Submission 34*, p. 3.

130 Ms Georgia Zogalis, National Program Manager, Multicultural Mental Health Australia, *Committee Hansard*, 17 June 2011, p.9.

131 Ms Georgia Zogalis, National Program Manager, Multicultural Mental Health Australia, *Committee Hansard*, 17 June 2011, p.10.

132 Ms Emma Cotterill, Acting Director, Social Support, Commonwealth Ombudsman, *Committee Hansard,* 14 October 2011, p. 29.

name but a few. Keeping all stakeholders abreast of developments can, at best, be described as a comprehensive challenge.

4.145 DEEWR said that it is acting on the *Falling through the Cracks* report recommendations, namely to update existing service delivery guidelines and training materials, and it provided the Commonwealth Ombudsman with a status report on those measures on 1 July 2011. The department stated that:

> DEEWR has either implemented the relevant recommendations made by the Commonwealth Ombudsman's report, 'Falling through the Cracks' or processes are well-developed to implement the recommendations.[133]

4.146 DEEWR said measures to improve communication and engagement include:

> the online mental health training package incorporates guidance for staff on how to ensure customers are aware of the benefits of disclosing a mental illness, and feel comfortable doing so. This will include information on how to foster an environment where disclosure can take place...DEEWR will continue to consider this recommendation with the development or enhancement of communication materials and staff scripts.[134]
>
> The Direct Registration Guidelines have been updated to include advice on what providers should consider if they identify that a job seeker may have mental health issues. Some suggestions include, seeking the assistance of a more experienced case manager or a JobAccess Advisor, organising alternative contact arrangements, consulting with the job seeker's nominee to determine the most suitable communication and contact arrangement, recommending that the job seeker discuss their circumstances with a mental health services provider, or referring the job seekers to other relevant support services.[135]
>
> The JobAccess Service has recently been expanded to include professionals in the mental health area who will provide information and support relating to the employment of people with mental illness...and includes funding to encourage

133 DEEWR, *Submission 75*, p. 3.
134 DEEWR, *Submission 75*, p. 7.
135 DEEWR, *Submission 75*, p. 4.

> employment service providers to access the expertise of the JobAccess Service.[136]

4.147 Centrelink says it too is making changes to strengthen decision making and reference material, specialist services and support to staff, through the following means:

- developing standardised 'pop-up' text when mental illness is mentioned in reference files. This will remind staff that consideration should be given to the various impacts on the customer's ability to comply, including their capacity to attend appointments;
- A Health Professional Advisory Unit (HPAU) established in July 20120 comprising medical practitioners and registered nurses to provide expert advice to Job Capacity Advisors, DSP decision-makers and Authorised Review Officers seeking clarification of medical evidence and/or information about treatment and rehabilitation regimes;
- In 2010, a total of 2, 428 staff participated in mental health first aid and mental health awareness training; and
- Piloting communication methodologies for people with disability as part of the DSP Workforce Reengagement Strategy. Face-to-face, phone, seminar and combined methodologies will be tested over a three year period.[137]

4.148 Centrelink officers described the range of communication strategies that the agency employs for communicating with other agencies and clients alike:

- Disseminating information to various groups through interagency forums and other seminars about what is happening; and
- We have promotional products which explain [concerns about losing benefits and some of the things that go with that].[138]

4.149 Ms Desley Hargreaves, National Manager, Social Work Services, Department of Human Services pointed to the challenges of communicating sometimes complex messages in accessible ways; to clients, namely:

> in simple ways that do help people to understand what their eligibility and entitlements are, and, when circumstances may change for them, what their options are.[139]

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136 DEEWR, *Submission 75*, p. 6.

137 DHS, *Submission 43*, p. 7.

138 Ms Desley Hargreaves, National Manager, Social Work Services, Department of Human Services, *Committee Hansard*, 4 November 2011, p. 12.

4.150 Ms Buffinton of DEEWR referred to money in the budget dedicated to training frontline staff, Centrelink and employment services providers alike, on dealing with people with a mental illness:

> In response [to the Ombudsman's report] we are pulling together a package of training material for the employment services and Centrelink staff.[140]

Training Centrelink and employment agencies staff

4.151 Ms Melissa Golightly Deputy Secretary, Health And Older Australians, DHS, spoke to the actual training staff receive and the suite of supports available to them to help them to do their job well:

> [staff] have at their fingertips access to properly trained and well-qualified social workers...and allied health professionals –health workers, nurses and that sort of thing, as well as psychologists, occupational therapists and doctors....for the frontline staff the focus is to be aware but not to feel that they have to deal with the issue themselves, and nor are they qualified to. We have an immediate escalation route or access route to a fairly significantly trained professionally qualified workforce.
>
> It is not the role of frontline staff to diagnose. Their role is to utilise flexibility, to demonstrate empathy and to have strong communication skills where a person is having mental issues...and to know when to call in the health professionals.[141]
>
> We have a range of training products targeted at staff in different roles. ...the training for [frontline staff as opposed to health and allied health professionals who already have tertiary qualifications in relevant fields]is more about awareness of mental health issues and disability awareness more generally, being able to identify where a person is having difficulty engaging with either the social security system or the employment assistance system, so that the person is able to exercise any flexibility that they have in the system in recognition that this person is having difficulty communicating, which is quite different from identifying the existence of a mental health condition per se.

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139 Ms Desley Hargreaves, National Manager, Social Work Services, Department of Human Services, *Committee Hansard*, 4 November 2011, p. 12.

140 Ms Fiona Buffinton, Group Manager, *Specialist Employment Services Group*, DEEWR, Committee Hansard, 14 October 2011, p.3.

141 Ms Malisa Golightly, Deputy Secretary, Health and Older Australians, DHS, Committee Hansard, 14 October 2011, p. 15.

4.152 Recognising the stressful situations that can present to Centrelink call centre and frontline staff by the very nature of the job, DHS indicated that its in-house cadre of professionals is available to help their own staff deal with the level of stress that can be experienced 'every single day of their lives and multiple times in one day'. [142]

4.153 The Committee certainly appreciates that the system can be incredibly complicated for consumers, service providers and Centrelink staff alike to navigate. It is not easy for anyone to follow, let alone someone with any kind of vulnerability, be it a mental illness or other, and supports all endeavours to enhance communication strategies, to clients, to staff serving clients and between agencies to support clients getting the services they need.

4.154 The Committee acknowledges that DHS/Centrelink and DEEWR themselves recognise this and are seeking to make improvements.

4.155 That noted, it is not clear that the agencies themselves are able to keep apace of the intensive pace of reform in the area, nor that the right messages are always reaching their intended audience.

4.156 Orygen Youth Health suggested that the marketing of employment services for people with mental ill health as 'disability employment services' may actually miss the intended target audience when:

> Most of our clients do not identify as having a disability and are consequently unlikely to follow up an ad that asks, 'Do you have a disability and want to work' (the wording used in one disability employment service that was advertised in our waiting room.[143]

4.157 A clear, effective and timely communication strategy to consumers that relays what services are available to them, and the potential impact of any introduced or other changes, pertinent to the client, should be of utmost priority. A range of visual, written and verbal communications will likely be necessary, in different languages. These might include a range of easy-to-read flyers to hand out to people, with case-study examples of people on the DSP/with identified mental illnesses who have ventured and/or transitioned successfully into employment and the ramifications of such moves for their pension entitlements, if any. Any explanatory guides and commensurate training provided to Centrelink and employment service providers to assist their clients in these areas should similarly disseminate

142 Ms Malisa Golightly, Deputy Secretary, Health and Older Australians, DHS, Committee Hansard, 14 October 2011, p. 15.

143 Orygen Youth Health, *Submission 28,* p. 4.

information in a timely and user-friendly manner. The communications strategy should be cognisant of a diverse audience, inclusive of people from all backgrounds, offer a positive message of assistance on offer and encourage engagement with the services.

Recommendation 13

The Committee recommends that DEEWR and Centrelink prioritise the implementation of a clear, effective and timely communication strategy that advises clients of the services and supports available to them, including how changes like the participation requirements and revised impairment tables will affect them.

The Committee expects that any accompanying explanatory guides and commensurate training provided to Centrelink and employment service providers by DEEWR and DHS to assist clients with mental health conditions will similarly be provided in a timely manner and user-friendly format.

Consumer input into policy change

4.158 Ms Lawson from the Welfare Rights Centre pointed out how vital it is to incorporate consumer participation in developing and altering welfare policy:

> It is the 'nothing about us without us' kind of concept. There need to be people with mental health issues involved at all levels of policy development.[144]

4.159 Ms Hargreaves from DHS referred to the existence of a national disability reference group that includes representatives of peak bodies who advocate on behalf of disability constituents.[145]

4.160 The Committee thinks that it is equally important to consult Centrelink staff and employment service providers as they are the interface between the client and the system.

144 Ms Lawson, Welfare Rights Centre, *Committee Hansard*, 9 August 2011, p. 26.

145 Ms Desley Hargreaves, National Manager, Social Work Services, Department of Human Services, *Committee Hansard*, 4 November 2011, p. 12.

Recommendation 14

The Committee recommends that any new communication strategies be developed with input from clients and staff (from both Centrelink and employment service providers) into how best to disseminate information to clients so they can readily understand any changes to their entitlement and participation requirements.

4.161 The Committee heard anecdotal evidence that DEEWR staff responsible for disability employment policy do not regularly visit Centrelink sites. In addition to any inter-departmental contact that DEEWR and DHS have, the Committee also thinks it important that DEEWR officers working on policy that affects DHS, regularly visit Centrelink offices so that they may have a first-hand appreciation of the impact of DEEWR policy on service delivery practice for consumers and staff.

Community engagement officers

4.162 Dr Waghorn called for the reintroduction of disability liaison officers as one way to improve engagement between the consumer and Centrelink. Previously located within Centrelink offices, they had, he said, served pension recipients well. He himself had been a disability liaison officer and seen first- hand the benefits of being able to offer specialist one- on-one advise to clients, helping individuals work out what they were required to do and the ramifications of any changes for their benefit entitlements.[146]

4.163 Mrs Melissa Williams, Manager, Gold Coast Employment Support Service indicated that the disability liaison officer positions in Centrelink had served providers like her well too:

> Years ago we had disability liaison officers at Centrelink who were trained and who were a one-stop shop for any concerns. It was the saddest day when they were removed. Trying to get any assistance through Centrelink is time consuming even for me as an agency, let alone for people who have these significant barriers. It gets all too hard and stressful a lot of the time and, rather than linking our services and getting things more smoothly, it is a deterrent. So I would say bring back the disability officer.

146 Dr Geoffrey Waghorn RM, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, *Committee Hansard*, 9 August 2011, p. 16.

> Centrelink can be overwhelming and intimidating, especially for people that are not really well and even if you are really well.[147]

4.164 Ms Gail Middleton, Executive Director, Welfare Rights Centre did not disagree but said:

> The trouble is you cannot have a single approach. To bring back disability officers would be good, but it does not replace the fact that some people are fearful of Centrelink itself. Some people need other safeguards in place and there needs to be more information out there for the people who interrelate with recipients...[148]

4.165 Dr Geoffrey Waghorn also spoke to clients' fear of Centrelink itself:

> Even if you go through with a person and show them using a budget calculator that their rate of DSP is only going to go down by that much, but their earnings are going to go up by that much and are only going to pay that much tax and the net gain is going to be $35 a week from 10 hours a week employment...even if you show them that, they will come back and say, 'But I can't deal with the stress of having to deal with Centrelink."[149]

4.166 Ms Desley Hargreaves, National Manager, Social Work Services, DHS observed that the right messages may be being relayed to an individual but, 'it is not always being processed or understood' [when someone is ill].[150]

4.167 Mr Peter Ball, Service Leader, Department of Human Services outlined how the presence of 'community engagement officers' in Tasmania had made a difference there:

> We have community engagement officers who operate in the three rough geographic areas of Tasmania, the south, the north-east and north-west...they go into the neighbourhood houses and the like and they work directly with those people to make sure that they continue to be engaged.[151]

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147 Mrs Melissa Williams, Manager, Gold Coast Employment Services,*Committee Hansard*, 8 August 2011, p. 13.

148 Ms Gail Middleton, Executive Director, Welfare Rights Centre, *Committee Hansard*, 9 August 2011, p. 29.

149 Dr Geoffrey Waghorn RM, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, *Committee Hansard*, 9 August 2011, p. 16.

150 Ms Desley Hargreaves, National Manager, Social Work Services, DHS, *Committee Hansard*, 4 November 2011, p. 16.

151 Mr Peter Ball, Service Leader, DHS, *Committee Hansard*, 4 November 2011, p. 16.

4.168 The Community Engagement Officers program offers outreach assistance in a wide range of locations, including mental health units. Community Engagement Officers keep services connected to the client, and can assist clients in an environment where they can be supported by other people such as hospital staff.[152]

4.169 This program seems to be one way to break down barriers between the client and Centrelink, and increase the likelihood of the right connections being made.

PHaMS Remote Service Model

4.170 Another example of a complementary service model is the PHaMs Remote Servicing Model which aims to better service Indigenous Australians in remote areas:

> The PHaMs remote service model differs to the mainstream service, with a strong focus on spiritual, cultural, mental and physical healing for Indigenous Australians. The model incorporates more traditional cultural healing practices and utilises broader community activities to support healing. It aims to enable social inclusion and strengthening of family and community relationships for the participant, as well as the development of the community as a whole.
>
> As part of this new remote servicing model, FaHCSIA partnered with a young designer, photographer, the PHaMs team (Warra-Warra Kanyi) and the Warlpiri people of the Yuendumu community, to develop promotional products that better reflected the remote Indigenous communities PHaMs would now be operating in.
>
> A workshop was held in the community and over a week, the local community members designed the concept that would represent PHaMs and what mental illness means in an Indigenous context. The local landscape was photographed and incorporated into the background and border. The community was given final sign off of the cultural appropriateness of the products before they could be used.[153]

152 Centrelink website, http://www.humanservices.gov.au/customer/services/Centrelink/community-engagement-officers

153 FaHCSIA website, http://www.fahcsia.gov.au/sa/mentalhealth/progserv/PersonalHelpersMentorsProgram/Pages/default.aspx#4

4.171 The PHaMS program was outlined in some detail in Chapter two and endorsed by a number of witnesses as adding value to their educational and employment prospects.

4.172 The FaHCSIA website indicates that Round 4 funding (until 30 June 2012) includes over $36 million funding for additional PhaMS services (in 17 current and 10 new sites) focusing on particularly vulnerable people experiencing mental illness such as:

- those who are homeless or at risk of homelessness
- humanitarian entrants, and
- Indigenous Australians. [154]

4.173 The Committee believes it could be beneficial to raise the profile of programs that help job seekers with a mental illness link to job opportunities, such as Centrelink community engagement officers and PHaMs,, as part of the national education campaign that the Committee recommends in chapter one.

Encouraging inter-agency communication and case-coordination

4.174 Having effective communication channels between agencies and clients is one very important part of the equation for assisting people with a mental illness get the services they need to find and sustain employment. Another integral component is effective inter-agency communication and coordination.

Collaborative partnerships, integrated employment services and strength based approaches

4.175 One of the resounding messages of the inquiry is the importance of leveraging collaborative partnerships and ensuring that employment services are integrated with clinical and social services to make them easier to access and more effective for consumers.

4.176 Disability Employment Australia would like to see employment service specialists work together with the assessors:

154 FaHCSIA website, http://www.fahcsia.gov.au/sa/mentalhealth/progserv/PersonalHelpersMentorsProgram/Pages/default.aspx#4

> To increase the appropriateness and accuracy of these judgements, as we believe that decisions around that economic potential are best made in context and in partnership with the participant and provider – based on a strength based and person centred assessment approach.[155]

4.177 Ms Melissa Lond, National Manager, Mental Health, Disability and Carers, DHS said that Centrelink, as a service agency, needs to employ strength based strategies to help people understand that they can test their workability.[156]

4.178 Ms Malisa Golightly of DHS elaborated on a strength based perspective:

> It is focusing on what [clients'] strengths are rather than what the problems are. That is not to ignore the problems, but it is a way of getting people into a space where you are building confidence for a start, but you are able to talk about options. We have seen this work really well through place based activities that we are doing.[157]

4.179 DHS added that:

> Utilising a strength-based approach builds the trust and confidence of vulnerable people to access services and support in their community.[158]

4.180 The Queensland Government states:

> Providing strengths-based training within an individual's recovery plan would assist in building their ability to participate in education, training or employment.[159]

4.181 Other witnesses agreed. Headpsace:

> recommends that the government focus on enabling, strength-based policies, holistic support, and the creation of meaningful jobs for young people.[160]

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155 Disability Employment Australia, *Submission 48*, p. 7.

156 Ms Melissa Lond, National Manager, Mental Health, Disability and Carers, DHS, *Committee Hansard*, 14 October 2011, p. 11.

157 Ms Malisa Golightly, Deputy Secretary, Health and Older Australians, DHS, *Committee Hansard*, 14 October 2011 p. 11.

158 DHS, *Submission 43*, p. 8.

159 Queensland Government, *Submission 56*, p. 36.

160 Headpsace, *Submission 13*, p. 13.

4.182 The following initiatives or models are all examples of a strengths-building approach that integrates employment specialists and adopts a collaborative modus operandi:

- the Place Based Services Program (PBS), which was a precursor pilot for case-coordination;
- the Local Connections to Work Program (LCTWP);
- Local Employment Access Partnerships (LEAP);
- the co-location of CRS, VETE and Headspace;
- Early Psychosis Prevention and Intervention Centre (EPPIC) and Individual Placement and Support (ISP) exemplified by Orygen Youth Health;
- the Queensland Health model-complex needs panels;
- and the Southern Adelaide Health integrated services approach.

Place Based Services Program (PBS)

4.183 DHS referred to ways it has sought to better reconnect people with services, including through the Place Based Services Program trial:

> In 2008/2009 Centrelink initiated the Place Based Services (PBS) Program to trial more intensive support for disadvantaged and vulnerable customers in seven geographic locations, aimed at producing more productive and sustained connections between the customer and support services within their community.
>
> Each trial site developed local responses to problems specific to their local area, developing responses to strengthen service delivery arrangements and build the capability of these networks to better respond to the needs of disadvantaged and marginalised people. In each case, responses were built around local partnerships between Centrelink, state and local governments and local business and community partners and importantly, marginalised Australians. [161]

4.184 According to DHS, key lessons learnt from this trial are informing the development of service delivery reform. These important lessons include that:

161 DHS, Submission 43, p. 7.

- Centrelink is one of the key agencies uniquely placed to identify and connect people to appropriate services;
- Working with people with significant disadvantage requires the involvement of highly skilled staff, including social workers and experienced Centrelink customer service advisors, cross-disciplinary teams allows for the optimal use of resources;
- The collaborative component within each initiative demonstrated the potential to improve social inclusion through advocacy, identifying and filling service gaps, better service delivery, networking and information sharing;
- Experience shows that building a relationship with a person who feels marginalised requires time, and multiple interviews. Investing this time has downstream benefits. Similarly, investing time to ensure that the person makes an effective transition to appropriate services is a critical element of achieving improved and sustainable outcomes.[162]

Local Connections to Work

4.185 DHS outlined the ethos behind the Local Connections to Work Initiative (LCTW) - which built on the PBS model. In existence since May 2010, and based on the successful New Zealand 'Community Links' model, LCTW aims to bring together a range of services under one roof to assist long-term unemployed and disadvantaged job seekers better access services:

> THE LCTW initiative brings together Australian, state and local government services, employment service providers and other community welfare organisations. Services provided include counselling, housing, mental health, youth, training and financial assistance. Community partners are co-located on rostered basis at the four Centrelink Customer Service Centres. This means that disadvantaged job seekers can 'tell their story once' and receive the range of wrap around services.[163]

4.186 Ms Malisa Golightly, Deputy Secretary, Health and Older Australians, DHS, spoke to the successes of the initiative for job seekers with a mental illness:

> Local Connections is very much a team effort where you have Centrelink, the employment service provider, and the local support, which might mean the mental health advisory service and the employer, all working together with the employee on

162 DHS, Submission 43, p. 8.

163 DHS, *Submission 43*, p. 9.

> what the strengths are of the employee and what might be possible. That is where we can do great things.[164]

4.187 One of the strengths of the LCTW model is its emphasis on local solutions for local people and the utilisation of community partners:

> The actual services provided on-site through LCTW are driven by local needs and tailored to the specific circumstances of job seekers and their families.
>
> Employment Services Providers play a vital role in this collaboration and on-site services are provided by both Job Service Australia and Disability Employment Services providers.
>
> Community organisations can get involved with the LCTW program by contacting their local office. You can be involved on-site or be a member of the Community Partnerships Group, which works towards finding ways to better deliver services to the community.[165]

4.188 Mr Peter Ball, Service Leader, DHS outlined the benefits to consumers and clients alike of the LCTW process:

> In our Burnie office, on the north-west coast, in February this year we commenced a process that we call Local Connections to Work...where we are bringing other agencies into our offices so that we can work on a partnership basis with the other agencies and with the individual customer. So it may well be that there is a joint interview with a job services provider and a Centrelink person. But also then, maybe, if there is an issue to do with alcohol and drug dependency, we have a direct referral and maybe a three-way conversation with those people as well.[166]

4.189 The program emphasises 'case coordination'. Mr Ball elaborated:

> We are allowing our people a longer period of time to have more in-depth conversations with people who have major or more apparent barriers to interconnecting and staying connected, so that we can make some direct referrals...it seems to us that what works more directly is, rather than making a referral and saying to someone you need to go up the road, we either make the

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164 Ms Malisa Golightly, Deputy Secretary, Health and Older Australians, DHS, *Committee Hansard*, 14 October 2011, p. 15.

165 Centrelink website, http://www.centrelink.gov.au/internet/internet.nsf/individuals/lctw.htm

166 Mr Peter Ball, Service Leader, DHS, *Committee Hansard*, 4 November 2011, p. 16.

> appointment [for the client], or better still take the person round the corner and up the road to that particular agency.[167]

4.190 The National Employment Services Association (NESA) praised the LCTW pilots from a service provider's point of view:

> We note that provider participation in the LCTW pilots report that in contrast to normal arrangements the assessment interviews jointly conducted by themselves and Centrelink in a face-to –face interview were highly effective at identifying a range of circumstances, including mental ill- health. These interviews were comprehensive and effective and worth the investment of resources with interviews taking an hour and a half in duration.[168]

4.191 The Centrelink website includes a video clip of one young woman citing her experiences and the range of help that LCTW gave, from securing stable accommodation through to finding a job and regaining self-esteem and confidence.[169]

4.192 LCTW has built on its successes and from June 2012, the program will operate from 14 service centres.[170]

4.193 The Committee watches the roll-out of the LCTW program to more sites with great interest and thinks it has real potential to assist clients with mental illnesses both find and sustain a job at the same time as deal with a raft of other issues they may have from a drug dependency to homelessness to need for advice on benefit obligations.

Local Employment Access Partnerships (LEAP)

4.194 The Australian Government provided $41 million to Innovation Fund projects that ran from 2009-2012:

> The Innovation Fund is a component of the Australian Government's national employment services, Job Services Australia. It is designed to address the needs of the most disadvantaged job seekers through funding projects that will foster innovative solutions to overcome barriers to employment which they may face. Innovation Fund projects also contribute to

167 Mr Peter Ball, Service Leader, DHS, *Committee Hansard*, 4 November 2011, p. 16.

168 NESA, *Submission* 41, p. 9.

169 Centrelink website, http://www.centrelink.gov.au/internet/internet.nsf/individuals/lctw.htm

170 Centrelink website, http://www.centrelink.gov.au/internet/internet.nsf/individuals/lctw.htm

> the achievement of the Australian Government's Social Inclusion Agenda by supporting innovative strategies to help the most disadvantaged job seekers find and retain employment.[171]

4.195 Social Firms Australia (SoFA) was the recipient of $1 million in funding from DEEWR's Innovation Fund to carry out its Local Employment Access Partnerships (LEAP) for Job Seekers with Mental Illness.[172]

4.196 LEAP was a three year project that ran until June 2012. According to the SoFA website:

> During this time, 340 + job seekers with a mental illness will be supported to manage anxiety and other symptoms and improve job readiness skills to secure and sustain employment.[173]

4.197 The Social Firms Australia (SoFA) website outlines the premise and strength of the LEAP approach, which was established in six localities in Victoria, five in Melbourne and one in regional Victoria:

> LEAP partnerships promote service integration and provide wrap-around support for people with mental illness who are preparing for paid employment. The partnerships meet on a quarterly basis and also collaborate to deliver the Health Optimisation Program for Employment (HOPE).
>
> HOPE assists job seekers with a mental illness to take greater control of their wellbeing and has been adapted from an evidence-based psycho-educational program.
>
> HOPE is delivered jointly by a mental health peer educator and facilitator.[174]

4.198 Ms Dea Morgain, Manager, Workplace Supports, SoFA, elaborated:

> [LEAP] brings together the clinical mental health services, the rehab services and the employment services and provides the opportunity for those services to actually speak to each other outside of the requirements of case planning, so that there are established relationships...between clinicians and employment services...the discussions vary between the partnerships but they

171 DEEWR website, http://www.deewr.gov.au/Employment/JSA/Pages/innovationfund.aspx

172 See DEEWR website for details on the various Innovation Fund projects, http://www.deewr.gov.au/Employment/JSA/Documents/InnovationFundprojects.pdf viewed 23 February 2012.

173 SoFA website, http://socialfirms.org.au/what-we-do/leap-hope viewed 23 February 2012.

174 SoFA website, http://socialfirms.org.au/what-we-do/leap-hope viewed 23 February 2012.

undertake service-mapping, trying to identify gaps in service delivery.[175]

4.199 Ms Morgain later provided an independent evaluation from the company 'Effective Change' which found the successes and outcomes of the LEAP partnerships to be:

- Improved communication between agencies about strategies to assist job seekers with mental illness to achieve their vocational aspirations.
- Increased inter agency referrals and improved referral protocols. In one partnership this has resulted in the employment service locating an employment consultant at the mental health clinic.
- A better understanding on the part of mental health clinicians of the services provided by employment services, Centrelink procedures and vocational rehabilitation approaches. Improved knowledge of mental illness diagnoses, symptoms and treatments on the part of the employment services.
- All partner agencies have felt that the benefits of belonging to the partnership have significantly outweighed the time required to be involved.[176]

4.200 Ms Morgain added that while funding for the project ceases on 30 June 2012, the partner agencies from each area intend to continue meeting and SOFA will assist as resources allow.[177]

CRS , VETE and Headspace

4.201 Headspace was launched in 2006 and is funded by the Australian Government under the Promoting Better Mental Health –Youth Mental Health Initiative. There are 30 Headspace centres around the country, in each state and territory, metropolitan, regional and remote locations. These provide youth-friendly community based services to young people aged 12-15. All Headspace centres have a suite of services on offer, including allied health, drug and alcohol workers and mental health practitioners.[178] Centrelink and CRS are other services on-hand, specifically to help young people access education, training and work opportunities.

175 Ms Dea Morgain, Manager, Workplace Supports, SoFA, *Committee Hansard*, Melbourne, 19 August 2011, p. 25.

176 Email from Ms Dea Morgain, Manager, Workplace Supports, SoFA, *Exhibit 42*.

177 Email from Ms Dea Morgain, Manager, Workplace Supports, SoFA, *Exhibit 42*.

178 Headpsace, *Submission 13*, p. 2 and see Headspace website: http://www.headspace.org.au/headspace-centres

4.202 The Committee visited the Central Coast Headspace in Gosford on the same day that it visited Youth Connection's[179] Green Central site (see Chapter two for more on that visit).

4.203 In addition to Youth Connection, Headspace Gosford's other consortium partners comprise: NSW Government Health Central Coast Local Health District (the lead agency); NSW Government Central Coast Local Health Network –Central Coast Children and Young People's Mental Health (CC CYPMH); the NSW Government Central Coast Local Health Network – Area Drug and Alcohol Services – Central Coast Sector; Central Coast Division of General Practice; and The Brain and Mind Research Institute.[180]

4.204 Headspace is co-located with Y-Central at the Gosford site.

4.205 The Y-Central website sets out its mission:

> Y-Central is funded by NSW Health, through the Youth Mental Health Service Model – Central Coast pilot project.
>
> The CYMPH Program is oriented towards mental health promotion, prevention and early intervention. The program's youth-friendly venue, y-central, promotes easy access to mental health services for children (12-25years) and their families. There are also crisis entry points for children and young people to promote engagement and the provision of comprehensive assessments and appropriate management. [181]

4.206 Other services available to Gosford clients on-site include Wesley Mission's Get it together (GIT) program and a tenancy advisory service.[182]

4.207 Headspace was another strong advocate of integrated holistic services (drawing on and endorsing the research findings of other expert witnesses to the inquiry, such as Professor Killackey and Dr Geoffrey Waghorn).

4.208 Headspace pointed to the many benefits of having a vocational intervention co-located with a clinical service, including:

- [in relation to Killackey's 2008 study into a group of young people with first episode psychosis], that young people

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179 Youth Connections is an organisation that helps young people aged 11-19 years to access employment, education, training and recreational opportunities on the Central Coast. See the website for details: http://youthconnections.com.au/

180 Headspace Gosford website, http://www.headspace.org.au/headspace-centres/headspace-central-coast/consortium-partners

181 See Y-central website for more: http://www.ycentral.com.au/about-us

182 Y- Central website: http://www.ycentral.com.au/about-us

receiving this intervention were more likely to gain employment, worked more hours, earned more money and stayed employed longer than the group of young people who did not receive the vocational intervention; and

- [in relation to Waghorn and Drake's 2003 study], that integrated services have the following advantages:
  - ⇒ Lower client drop-out rate
  - ⇒ Clinical information gets into vocational plan preventing job loss
  - ⇒ Both health and vocational outcomes are optimised
  - ⇒ The clinical team can help with assessments
  - ⇒ Employment goals lever treatments; and
  - ⇒ Employment staff facilitate timely re-access to mental health services.[183]

4.209 Established in 2007 to provide employment and education support to people receiving community mental health services in the Northern Sydney and Central Coast regions, Vocational Education, Training and Employment (VETE) is part of Northern Sydney and Central Coast Local Health Districts. VETE consultants with experience from federally-funded employment programs are recruited and employed within health service funding.[184]

4.210 The service caters for people in the public mental health system, and seeks to improve their participation in education, training and employment.[185] A VETE employment consultant is co-located with the CC CYMH and Headspace precinct in Gosford, working two days a week with young people with a diagnosed mental illness.

4.211 VETE interventions are tailored to the individual and may include the following forms of advocacy and assistance:

- Vocational counselling
- Benefits counselling – to assist consumers understand Centrelink guideless regarding the number of hours they are permitted to work and the impact of income from employment on their Centrelink benefits
- Direct referral to Disability Employment Services
- Gathering supporting medical documentation required by consumers attending the Employment Services Assessment (DHS process)

183 Headspace, *Submission 13*, p. 9.

184 VETE, NSW Ministry of Health, *Submission 70*, pp.1-3.

185 VETE, NSW Ministry of Health, *Submission 70*, p. 8.

- Facilitating the communication of relevant disability related information between internal and external service providers
- Monitoring consumers rehabilitation progress once they have been linked with a suitable DES provider
- Supporting consumers to identify suitable courses and to enrol at educational institutions like TAFE
- Referral to specialist disability support services at TAFE and University
- Providing resources to clinicians and consumers regarding vocational/career/training information
- Assisting with the identification of suitable volunteer positions
- When required, developing plans with consumers to make a gradual transition towards employment taking into account their skills, mental and physical fitness, social and interpersonal skills and understanding of the labour market.[186]

4.212 VETE provided data indicating the numbers of people helped into employment, education and training, across all four sites, including Gosford.

4.213 VETE states that the following positive outcomes account for 70% of the 1776 individuals who proceeded with the VETE Service (out of 2000 referrals in the last 5 years):

Figure 4.3 Vocational Outcomes 2007-2011

Outcomes	Number of clients
Employment	246
Education / Training	218
Improved Vocational Skills / Resources	421
Linked with Employment Service Providers	257
Volunteer Work	53
Social Participation	42

Source VETE Submission 70, p. 8.

4.214 VETE pointed to an oversubscription of its Gosford service and the heavy workload to-date on its one part-time (0.4 FTE) VETE consultant:

> Since 2007, approximately 400 referrals for vocational and educational services have been received, which equates to 100 referrals a year. Data from Central Coast Headspace indicates that for the 12 month period from July 2010-to June 2011, there were 127 young people accessing Headspace who presented for mental health issues and also expressed an interest in or demonstrated a need for vocational services....[but] were not eligible for VETE

186 VETE, NSW Ministry of Health, *Submission 70*, p. 6.

> services because they did not meet the criteria for CCCYPMH. Using this as a guide, an increase in VETE would be warranted in order to provide vocational support for more young people.[187]

4.215 VETE highlighted the importance of inter-agency cooperation and network building between agencies providing vocational services for people with a mental illness:

> The aim of the partnerships is to break down barriers between organisations and share information of mutual benefit by having improved access to external programs, including TAFE and DES.[188]

4.216 VETE says it achieves this through regular interagency committee meetings and participation in a variety of separate meetings organised by external partners e.g. with Centrelink and the National Disability Coordination Officer.[189]

4.217 Underpinning the success of a co-located venture such as that between Headspace, Y-Central, VETE and various other service providers at the Gosford site, is an agreement between the parties to work together. Physical co-location may be an added benefit, but may not necessarily be critical. Ms Susan Robertson, Managing Director, Edge Employment Solutions suggested:

> I think the critical element is the agreement between the job seeker, their clinical provider and the agency all signing off on the need to contact each other regularly, and having that agreement in place at the outset. That will produce the best outcome. The co-location is just an added issue that may be a bonus or not.[190]

Orygen Youth Health - Individual Placement and Support (IPS)

4.218 Orygen Youth Health (OYH)'s principal recommendation to the committee was that:

> Mental health care and vocational support for young Australians with mental illnesses should be integrated and co-located in appropriately resourced youth platforms headspace and EPPIC.[191]

187 VETE, NSW Ministry of Health, *Submission 70*, p. 5.

188 VETE, NSW Ministry of Health, *Submission 70*, p. 7.

189 VETE, NSW Ministry of Health, *Submission 70*, p. 7.

190 Ms Susan Robertson, Managing Director, *Edge Employment Solutions*, Committee Hansard, 18 October 2011, p. 27.

191 Orygen Youth Health, *Submission 28*, p. 1.

4.219 Professor Eoin Killackey believes this is important because it is so difficult for people to have to navigate their way through separate services, mental health, and employment.[192] OYH claims that this difficulty is compounded by poor coordination between the two and the two different systems have two sets of priorities that may not always align.[193]Moreover:

> Employment is a key rehabilitative part of the process of someone's journey towards recovery; it is not something else.[194]

4.220 Orygen asserted that:

> Headspace for moderate to mild mental ill-health and EPPIC for serious mental illness –can provide this type of integrated clinical and employment support to young Australians. Currently these service platforms are not readily available to most young Australians who could benefit from them.[195]

4.221 As noted earlier in this chapter and in chapter one, the Commonwealth Government, through the federal budget, has recognised the utility of and committed additional funding to expand both the headspace and EPPIC models.

4.222 The OYH organisation, based in Melbourne, provides comprehensive clinical services to young people aged 12 – 25 years with mental health issues in the western and north-western areas of Melbourne. Their services include inpatient, acute, outreach, case-management, psychosocial programs, peer and family support.[196]

4.223 Professor Killackey, Director, Psychosocial Research, OYH, described the service further:

> It sees people from a catchment area of around one million people, of which around 250, 000 are in the age range from 15-25. Each year it receives around 2000 referrals and can take on around 700 of those people. It does that under two main areas. One is the early psychosis area, which is called EPPIC. The other area deals with

192 Professor Eoin Killackey, Director, Psychosocial Research, Orygen Youth Health, *Committee Hansard*, 13 April 2011, p. 18.

193 Orygen Youth Health, *Submission 28,* p. 3.

194 Professor Eoin Killackey, Director, Psychosocial Research, Orygen Youth Health , *Committee Hansard*, 13 April 2011, p. 18.

195 Orygen Youth Health Research Centre, *Submission 28*, p. 3.

196 Orygen Youth Health website, http://oyh.org.au/about-us

people who have non-psychotic illnesses, which is broadly called Youthscope, and there are a number of sub-clinics to that.[197]

4.224 The website for the Early Psychosis Prevention and Intervention Centre outlines the EPPIC program, namely that it is a dedicated early psychosis service within a dedicated youth service, Orygen Youth Health, and involved in research activities, primarily through the Orygen Youth Health Research Centre:

> The aims of EPPIC are:
>
> - Early identification and treatment of the primary symptoms of psychotic illness
> - Improved access to and reduced delays in initial treatment
> - Reducing frequency and severity of relapse, and increasing time to first relapse
> - Reducing secondary morbidity in the post-psychotic phase of illness
> - Reducing disruption to social and vocational functioning and psychosocial development in the critical period following onset of illness when most disability tends to accrue
> - Promoting well-being among family members and reducing the burden for carers
>
> The aims of treatment are:
>
> - Explore the possible causes of psychotic symptoms and treat them
> - Educate the young person and their family about the illness
> - Reduce disruption in a young person's life caused by the illness, restore the normal developmental trajectory and psychosocial functioning
> - Support the young person and their carers through the recovery process
> - Restore normal developmental trajectory and psychosocial functioning
> - Reduce the young person's chances of having another psychotic experience.[198]

4.225 OYH's research arm, the Orygen Youth Health Research Centre, has developed innovative service models and conducted leading research in

197 Professor Eoin Killackey, Director, Psychosocial Research, Orygen Youth Health, *Committee Hansard,* 13 April 2011, p. 12.

198 EPPIC website, http://eppic.org.au/about-us

the area of vocational rehabilitation for young people with psychosis and other mental illnesses. It is worth noting that OYH believes that many of the observations and recommendations it makes for this cohort would also be valid for older age groups too.[199]

4.226 The third tranche of OYH's work is its training and communications program which seeks to provide training and resources to improve the understanding of mental health issues in young people and to promote the capacity of the general public to support young people. OYH works with a range of organisations from health services, schools, drug and alcohol services, corporate organisations and sporting groups to achieve this.[200]

4.227 The Committee visited Orygen Youth Health premises on 12 April 2011 to meet with staff and clients.

4.228 Professor Killackey outlined OYH's research agenda and outcomes to-date. He said:

> We did the first-ever trial in the world of an employment intervention for young people with first episode psychosis, and following on from that we are doing a much bigger trial, which we just started recruiting for last week, that will be the biggest trial of its sort in the world and should give us a better ability to answer questions around the economics of this sort of intervention as well as answer things like: do people who get jobs use health services less, do they have fewer symptoms, do they use fewer drugs, do they just generally have better and more productive lives?[201]

4.229 Essentially:

> Research in Melbourne (by Orygen Youth Health Research Centre) and in the USA demonstrates that 85% of this group of young people can return to work or education if provided with an intervention that integrates in one service platform both timely, evidence based clinical care and intensive employment support.[202]

4.230 Orygen utilises the Individual Placement and Support (ISP) method of supported employment. ISP is a group of interventions that aims to helps

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199 Orygen Youth Health website, http://oyh.org.au/about-us and Orygen Youth Health Research Centre, *Submission 28*, p. 1

200 OYH website, http://oyh.org.au/about-us

201 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne, *Committee Hansard*, 24 March 2011, p. 1.

202 Orygen Youth Health Research Centre, *Submission 28*, p. 3.

people get into employment quickly and supports them there. It adheres to seven principles:

- Competitive employment
- Open to anyone, no work readiness assessment
- Immediate job searching
- Integrated within a mental health program
- Jobs based on consumer preference
- Time unlimited support
- Personalised benefits planning.[203]

4.231 Professor Killackey emphasised that IPS harnesses people's enthusiasm and clarified that Orygen offers 6 months of support, rather than time-unlimited support, for funding reasons.[204]

4.232 Early intervention is integral to the IPS model. Professor Killackey pointed to the potential to keep people away from going down the, potentially demoralising and dispiriting DSP path:

> Early intervention around these issues might actually circumvent some people- or perhaps quite a lot of people- starting on the DSP.[205]

> Being on a DSP is a safe place to be, but there would be very few people on the DSP, I imagine, who feel that they are achieving the potential that they wanted to achieve in their life.[206]

4.233 Professor Killackey indicated that the results so far are very promising. Referring again to their 85% success rate, and others, he elucidated:

> There is an average return across nine studies in the US, Europe and Asia of 61 per cent compared to 23 per cent in all the various control groups that they were using. There have been two randomised controlled trials in first episode psychosis now: ours and another one at UCLA. Ours got 85% back to school or work {out of 41 people in total: 20 and 21] and the one at UCLA got 83 per cent {out of 60 people: 30 and 30].[207]

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203 Orygen Youth Health, *Submission 28*, p. 6.

204 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne, *Committee Hansard*, 24 March 2011, pp. 5-6.

205 Professor Eoin Killackey, Director, Psychosocial Research, Orygen Youth Health, *Committee Hansard,* 13 April 2011, p. 18.

206 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne, *Committee Hansard,* 24 March 2011, p. 13.

207 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne, *Committee Hansard*, 24 March 2011, pp. 5-6.

4.234 Professor Killackey stressed that the improvement is significant:

> It is like a three –to fourfold difference.[208]

4.235 Ms Gina Chinnnery, employment consultant described her role at Orygen as 'finding people the kind of work that they want to do and following that up with support'.

4.236 Ms Chinnery described the support she offers, some of which she says might seem 'basic stuff' –be it how to answer the phone to dressing appropriately for interviews and obtaining a tax file number- but not to those who come from families who have only ever known being on welfare:

> With quite a few of the clients I work with, their parents have never worked-they have always been on the pension or the dole...so it is a real learning experience for them too.[209]

4.237 That said, she emphasised how keen most young people were to work, and were supported to do so by their families:

> They have volunteered for this service and they just want things to get moving as soon as possible...we kind of steer away from that prevocational job search training stuff, because you are just spending all this time talking and they are getting bored waiting.[210]

4.238 Miss A, a client of Orygen Youth Health said that, by contrast, her family had not been supportive, but she could rely on, and valued, her professional support networks.[211]

4.239 Professor Killackey commented on the intensive level of support provided during the six month period, and the subsequent trust and rapport built up between the employment consultant and client. One of the benefits of this approach is that it can act as an early warning system to detect and resolve any problems quickly:

> Quite often she will take people to work at the start and will be in close contact with them. Because she has achieved an outcome for them that they really quite value, quite often they will call her as a

208 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne, *Committee Hansard*, 24 March 2011, pp. 5-6.

209 Ms Gina Chinnery, employment consultant, Orygen Youth Health, *Committee Hansard*, 13 April 2011, p. 19.

210 Ms Gina Chinnery, employment consultant, Orygen Youth Health, *Committee Hansard*, 13 April 2011, p. 19.

211 Miss A, Committee Hansard, 13 April 2011, p. 19.

> first point of contact rather than their case manager., so she is aware of when things begin to deteriorate, quite often, earlier than the mental health system is and earlier than the employer. She is able to put in place a program to manage that. For some people that involves talking to the employer.[212]

4.240 In terms of scaling up Orygen Youth Health's employment consultant model, Professor Killackey said that his ARC funded study will determine the economic benefits or otherwise of so doing:

> We have just finished recruiting for that study, so it still has 18 months to run before we finish collecting that data...We did a really rough back of the envelope analysis after the first study, looking at how much it costs us to employ Gina and what outcome payments we would have got had she worked through the Job Network or one of the job service agencies. It pretty much just broke even. It is not a diligent economic analysis, but that is why I have involved economists in the ARC study.[213]

4.241 Professor Killackey said that they cap their case load for their employment consultant at 20: to give the client the individual support and attention that they really require, and it was on that basis that she broken even, but admitted that was financially difficult:

> We would probably struggle now, but that is more to do with the University of Melbourne's pay rises in the last few years than it is with the market rate for an employment consultant.[214]

4.242 Professor Killackey's observations are consistent with Dr Waghorn's findings that case loads in the employment services can be too high. In his experience, 25 or fewer per employment specialist tends to work very well. Dr Waghorn advised:

> What we find happens is that if we get the case load to 25 people or fewer, even if they have severe disabilities does not matter...We then get the employment specialist to adopt the evidence based practices and then do things with stuck clients, like not to ignore stuck clients. ..You need to be doing something with people every week..We have found that employment specialists who actually do

212 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne, *Committee Hansard,* 24 March 2011, p. 10.

213 Professor Eoin Killackey, Psychosocial Research, Orygen Youth Health, *Committee Hansard,* 13 April 2011, p. 20.

214 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne *Committee Hansard,* 24 March 2011, p,11.

> these practices and follow through with every client and provide good post-employment support service achieve way in excess of even the research expectations – 100 per cent employment outcomes is possible, even in impoverished labour markets. The Thames-Coromandel Peninsula in New Zealand is one really good example. ...there is almost no employer to be seen. There is the occasional run down corner store...You just cannot see any employers, but there is an employment specialist there, Workwise Employment Agency, who gets almost all of her clients into employment, every time. ...She gets to know everything in her territory and she is actively involved.[215]

4.243 While the studies have been with consumers with psychosis, Orygen opens that service up to its broader client base (which includes people with depression, anxiety and personality disorders) in between studies and has found that:

> Not that we have systematically evaluated that, but there seems to be a great deal of satisfaction of the case managers in those clinics that their clients are getting employment or education outcomes from that service.[216]

4.244 Orygen mentioned an interesting research gap, namely a lack of research on educational interventions. They say there is evidence to suggest that where education is included in an IPS approach that people make a transition from education to work. In a pilot study that Orygen completed with 19 young people, they found that with a similar approach to that taken for employment interventions, namely early intervention and intensive support, 18 of them achieved successful educational outcomes.[217]

4.245 Orygen would ideally like to see employment consultants funded as members of mental health services and that they be called vocational recovery or vocational rehabilitation services, thereby moving away from an association with disability terminology.[218]

4.246 The next section on state approaches will consider what New South Wales, Queensland and South Australia are doing in respect to integrating employment consultants in their public mental health services.

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215 Dr Geoffrey Waghorn RM, Head, Social Inclusion and Translational Research, Queensland Centre for Mental Health Research, *Committee Hansard*, 9 August 2011, p. 14.

216 Professor Eoin Killackey, Centre for Youth Mental Health, University of Melbourne, *Committee Hansard*, 24 March 2011, p. 11.

217 Orygen Youth Health Research Centr*e, Submission 18*, p. 8.

218 Orygen Youth Health Research Centre, *Submisson 18,* 9.

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4.247 Professor Killackey of Orygen Youth Health told the Committee that he believed there was some fundng in New South Wales:

> I think there are about 20 people who work in the same capacity as Gina does across a number of mental health services, but as Laura [from Mental Illness Fellowship Victoria] said, what we probably really need is three or four people per mental service to do that.[219]

Queensland Health

4.248 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, spoke to the Queensland Government's commitment to placing employment specialists in a number of their mental health services.

4.249 Dr Groves described the Queensland Government's whole-of-government response, which targets people with a severe mental illness, in particular psychosis, because these are the people most likely to experience difficulty procuring employment, educational participation and social inclusion. However, he said the benefits extend more broadly to others with mental illness in the public mental health system. Overseeing this approach is a:

> ...peak government committee that consists of representatives from not only our education and training departments but also from [the Department of Employment, Economic Development and Innovation], Queensland Health, police, corrective services and Commonwealth Departments that are situated here in Queensland to make sure that all our programs can work together.[220]

4.250 Dr Groves backgrounded how, based on evidence from Dr Waghorn, and with drive and determination from consumer consultants (people in various stages of their own personal recovery who are now employed by Queensland Health), and also DES providers, Queensland Health had developed a pilot program called the Queensland Health Employment Specialist Initiative (Employment Specialist Initiative) in eight demonstration sites, spread across the state so that every district has a stake:

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219 Professor Eoin Killackey,Director, Psychosocial Research, Orygen Youth Health, *Committee Hansard*, 13 April 2011, p. 17.

220 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, *Committee Hansard*, 9 August 2011, p. 1.

> We gave funding to organisations to come and work within mental health teams. The idea was to try and break down the barriers- as much as with the mental health staff who probably have some of the most stigmatising attitudes toward people with mental illness in our community-about the issue of people with severe mental illness having the ability to go back into the workforce.
>
> [Consumer consultants] were the strongest advocates for saying to staff and to the DES providers, 'There are a whole bunch of people who really want to get a job; it is just that nobody has actually ever made those opportunities available to and open for them.' It probably took the best part of a year, but by and large that worked quite well in terms of breaking down some of those issues.
>
> The other thing that impressed us was that the feedback from the DEN providers, as they were then, was that to some extent we were probably the best value of money for them [because the clients wanted to work]..they came to us and said we actually do better with referrals from you that we do from other people who are coming out of other forms unemployment.[221]

4.251 The Employment Specialist Initiative co-located an employment consultant from a local DES in a public community mental health team to work collaboratively with consumers in helping to find work in the competitive employment market, using the evidence based supported employment model. Findings from the pilot included the following successful consumer outcomes:

- Increased independence, self-esteem and confidence;
- Increased sense of empowerment and control in life;
- Increased work skills and career opportunities;
- The development of new friendships; and
- Greater connectedness to the community.[222]

4.252 Dr Groves added:

> We have been able to get hundreds of people into some level of employment and some of them into full-time employment. This is for a group of people who most often the mental health service

221 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, *Committee Hansard*, 9 August 2011, p. 2.

222 Queensland Government, *Submission 56*, p. 47.

> would not believe they would have got any form of employment again. There are quite staggering case studies and histories.[223]

4.253 Queensland Health no longer funds this initiative, other than for research and collecting data, in order to 'better show the benefit of this' because:

> [Service providers] actually find it is a viable option for them in terms of their placements and the funding they get from the Commonwealth.[224]

Complex needs panels

4.254 Complex needs panels are another Queensland initiative. Dr Groves explained how they fit into the bigger picture of care-coordination:

> One of our [important whole –of-government approaches] is our care coordination approach where we have tried to get all those Queensland Government departments and those Commonwealth Departments that we can to agree to a common approach to taking away any barriers towards inclusion into programs. We noticed in 2006 when the COAG [mental health] plan was put in place that one of the common features was that different departments had different inclusion criteria and different exclusion criteria so somebody could be getting services from one government department but not form another. So we have developed MOUs and service agreements across all the Queensland Government departments to ensure that a particular group of people with the most complex needs get access to services as a priority, irrespective of where they might otherwise sit on a priority list. It has also been an important part of embedding that process that we have put in people in places to develop those relationships between service providers to ensure that if any gaps do crop up or if any barriers become apparent they are dealt with at the local level.[225]

4.255 Dr Groves set out how the 20 people employed as dedicated 'service integration coordinators' work across 17 districts in Queensland Health:

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223 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, *Committee Hansard*, 9 August 2011, p. 3.

224 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, *Committee Hansard*, 9 August 2011, p. 3.

225 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, *Committee Hansard*, 9 August 2011, p. 2.

> They set up a number of things, although complex needs panels are probably one of the most frequent things that they set up. Those people with the highest levels of needs – that is not everybody with a mental illness- can get referred to that panel. It is very good for sharing information without needing it to go through the usual blockages that the health system puts on sharing information with other agencies. That panel talks about what a person needs from more of a problem oriented approach than a symptom oriented approach. They key issue is identifying what types of services are required and how to provide them rather than what particular symptoms that a person has or obstacles that they face.[226]

4.256 One of the components key to the success of the care coordination approach appears to be obtaining senior leadership buy in. Queensland Government enlisted the support of director-generals of departments and regional directors and:

> In general, there is pretty good support for people to come.[227]

4.257 Another important factor is that:

> It is a very structured set-up which meets monthly and they are very committed stakeholders.[228]

4.258 The Committee met with members of the Gold Coast complex needs panel.

4.259 Ms Phyllis Quensier, Service Integration Coordinator, Gold Coast Health Service District, Queensland Health talked about the three panels that operate on the Gold Coast, catering for different demographics, and funded by various organisations. She explained that they are run separately, but panellists also work together and are 'constantly in touch':

> I believe we are quite unique in Australia on the Gold Coast because we actually have three panels that look at age groups from 10-64. I work for Queensland Health and I look at the 16-64 group with severe mental illness. Grant works for the Gold Coast Drug Council and he looks after the panel that looks at dual diagnosis between the ages of 17-29. Tanya is not here today, but

226 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, *Committee Hansard*, 9 August 2011, p. 4.

227 Dr Aaron Groves, Executive Director, Mental Health, Alcohol and Other Drugs Directorate, Queensland Health, *Committee Hansard*, 9 August 2011, p. 4.

228 Mr Grant Robin, Program Director, Gold Coast Drug Council and Queensland Drug and Alcohol Council, *Committee Hansard*, 8 August 2011, p. 23.

> we have another group that looks at the younger group, 10-17...auspiced by Wesley Mission.
>
> We sit on each other's panels. We also have annual summits where we meet. About 70 people attended last time we had one. All the different coordinators and panels go there. We talk about capacities, any trends or issues that are coming up, what works and what does not work, and we might give a case-study to show people an example of what we do on the panel.[229]

4.260 Ms Quensier explained how they work:

> They are all different, but I have one for three hours once a month. I have had up to four new clients and about three referrals of that client at one meeting, which involves a lot of discussion. I have about 50 clients on the books now, which is a lot.[230]

4.261 Mr Robin added that sometimes clients attend, other times they do not. The referring clinician comes and the employment services. Ms Quensier commented that 'Centrelink come ad hoc but they need to be there more regularly.'[231]

4.262 Ms Quensier emphasised how critical the notion of partnerships is to the complex needs panel concept:

> Partnerships are the biggest help. The people who sit on the panel and are committed to the panel and want to help are the biggest support system that we have. It helps with access, it helps with streamlining referrals and follow-up and it helps with gaps. [An example is sharing knowledge of clients so that for instance someone on a younger age group panel can be transitioned to another panel once they reach the age of 18].[232]

4.263 Mr Tawanda Machingura, Assistant Director of Occupational Therapy, Gold Coast Health Service agreed:

> I just want to emphasise community partnerships and give an example of what we are doing in the Gold Coast service. We know that for someone to have success in employment it is because there

229 Ms Phyllis Quensier, Service Integration Coordinator, Gold Coast Health Service District, Queensland Health, *Committee Hansard*, 8 August 2011, p. 21.

230 Ms Phyllis Quensier, Service Integration Coordinator, Gold Coast Health Service District, Queensland Health, *Committee Hansard*, 8 August 2011, p. 24.

231 Ms Phyllis Quensier, Service Integration Coordinator, Gold Coast Health Service District, Queensland Health, *Committee Hansard*, 8 August 2011, p. 24.

232 Ms Phyllis Quensier, Service Integration Coordinator, Gold Coast Health Service District, Queensland Health, *Committee Hansard*, 8 August 2011, p. 22.

> are a number of services working together. If we have a barrier in one of those services, then we are unlikely to get a good employment outcome. One of the things we have done is to have employment services be available to clients within the mental health service itself, and that works so well because they are available and it improves access to those services.[233]

4.264 Mr Grant Robin, Program Director, Gold Coast Health Service District, Queensland Health, spoke on behalf of his panel, the Complex Needs Assessment Panel and Integrated Services (CNAPIS), which often has employment services make referrals to it:

> We engage them and have a look. I can give a family as an example..she had so many issues with regard to a DV situation. ..There are a whole lot of other priorities. We as a collective can sit around the table and say, 'Well, although she has come through an employment stream and she is kind of being mandated to find a job, otherwise there will be implications for her benefit..hang on a second, there is a whole lot of other priorities that we need to address, there is a lot of advocacy that needs to happen, there need to be referrals, there needs to be management not only of her situation as the primary referral but also in the context of the family system...That is the wonderful work we can do.[234]

4.265 Ms Christine Shaw, Acting Coordinator, Mental Health Recovery Program, Ozcare summarised the positive impact the panels had on one of her clients:

> My usual role is that of mental health support worker. ..I work directly with clients on the ground level. I referred a client to a panel and supported him with the panel. I just cannot emphasise how valuable it was for this person to be at the panel. Probably one of the biggest benefits for him was having a lot of trouble from different services that actually have the power to say right there and then, 'I'll do this; I'll do that, and it is done and followed through. If we were to try to access those people out in the community, it would probably take three weeks, or maybe longer, of trying to arrange appointments and a lot of anxiety and stress for the clients waiting for letters to come back...When we left there the client said he felt like a weight had been lifted from his

233 Mr Tawanda Manchingura, Assistant Director of Occupational Therapy, Gold Coast Health Service, *Committee Hansard*, 8 August 2011, p. 23.

234 Mr Grant Robin, Program Director, Gold Coast Drug Council and Queensland Drug and Alcohol Council, *Committee Hansard*, 8 August 2011, p. 23.

> shoulders and that he hoped for a good outcome. His issues have become manageable. So the panel was excellent for that.

South Australia Health- an integrated service delivery model

4.266 The Committee visited the Noarlunga Adaire Clinic, a specialist mental health service providing mental health care in the community in outer suburban Adelaide in South Australia. The clinic serves emergency presentations, first presentation of an early disorder (early psychosis) and clients who require mental health assistance for a period up to six months.[235]

4.267 Mr Todd Bamford, Team Leader, Transitional Care and Early Psychosis, and Noarlunga Emergency Mental Health Services, Southern Mental Health, Adelaide Mental Health Service, South Australia Health spoke to policy development work he did and the preparation of a discussion paper about the benefits of bringing into being an integrated service delivery model where employment and clinical mental health services work together to help clients with a mental illness:

> The discussion paper was intended as a synthesis of the evidence based around better employment outcomes for people with serious mental illness as well as triggering some thinking amongst the relevant stakeholders around what sorts of different ways of working we would need to adopt to actually implement the evidence based practices for employment outcomes.
>
> The evidence was very clear that an integrated service delivery model is far more effective when you are looking at hours worked and the length of time in employment, and even simply rates of consumers achieving employment...From the mapping we did, it did not look like we had anything like that evidence based model in existence...We brought together stakeholders from non-governmental employment services, non-governmental mental health services, clinical mental health services, consumers and carers, education providers and Centrelink.. We consulted around the State...We were talking about bringing together two very complex systems, the employment services sector and the health services sector. We needed those stakeholders to tell us about the

235 Noarlunga Health Services, http://www.noarlungahealth.sa.gov.au/services/pages/mhealth/6668/

> problems and then start working on the solutions. – and they did that.[236]

4.268 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health provided some context for Mr Bamford's paper, saying that it complemented an earlier *Stepping up* report of 2007 which set the platform for broad reform in South Australia's mental health system and the state's commitment to giving staff the tools and system design to provide the services to better consumer outcomes. He described the very dedicated way that Southern Mental Health approached change management:

> W really worked hard on developing role clarity. One of the most important things for our services in public mental health is to be clear about the service, the roles and the functions that we provide. And that was the same for the disability employment services because, again, if you want to start busting myths around what we do, the clearer we are with our roles and functions, the greater the opportunity to work together.
>
> We did a lot of training and training requirements.
>
> Information sharing was a big issue....obviously this is driven by consumer consent. We made sure that with consumer consent, our medical records, or out case notes, were accessible to the disability employment staff. We wanted to make sure each one of our consumers in the public sector has a care plan. The intent of that care plan is a consumer-driven care plan, but we wanted the employment part of our partnership to be reflected in each consumer's participation in that care plan.
>
> We made sure there were some shared values and a shared vision for case reviews.....Other things were conflict resolution, points of accountability and starting out an evaluation process, **ensuring and really supporting that employment is part of the rehabilitation journey that our services provide.**[237]

4.269 Mr Strachan highlighted the commitment they put into getting people on board with the new concept:

> Engagement with staff...the pre-staff surveys and the post-staff surveys we have done really reflect a robust uptake of what

236 Mr Todd Bamford, South Australia Health, *Committee Hansard*, 7 June 2011, p. 22.

237 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 23.

> people saw as a positive way to deliver more effective rehabilitation services.
>
> There was a strong investment in supporting families and cares to understand that this is a positive journey for their loved ones, not something that is going to make them lose their DSP or make them fall over and go into hospital.[238]

4.270 From the consultative process consensus on a service model and service-level agreement was reached.

4.271 Mr Strachan set out how the new service commenced in the Trevor Parry Centre, a residential community rehabilitation service for consumers with severe and enduring mental illness, and has since also been adopted by Club 84, another psychosocial rehabilitation program in the north-east.[239]

4.272 Mr Strachan reported encouraging results thus far. At Noarlunga, over the past 11 months, out of 21 residents that have gone through the centre, 14 have now registered with the Employment Access Service and are talking about their employment options. Nine consumers have completed a job capacity assessment. Six people applied for paid employment. Three have enrolled in further study or training. And, four people have commenced voluntary work. He said:

> We feel very proud of these outcomes because prior to this opportunity none of these consumers were actively working with us to access open and full employment.[240]

4.273 Of Club 84's outcomes he stated:

> They have got three hours a week with a disability employment service provider coming in and being part of the integrated team. They have had 20 consumers register with Employment Access. They have had eight complete a JCA. Five have completed resumes. They have had four who applied for paid employment. Six individuals attended interviews. We have had four who commenced and been successful in gaining paid employment, and this is full employment. We have had three who have undertaken further studying and training, and four who have undertaken and commenced volunteer work. So again, some really wonderful

238 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 24.

239 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 24.

240 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 24.

> outcomes and, again, working with those consumers with the most severe and enduring mental illness and disabilities associated with that.[241]

4.274 The success of this integrated employment service and clinical mental health service model is underpinned by an equally committed disability employment provider, in this instance, UnitingCare Wesley Port Adelaide Employment Access service:

> They really saw the benefit of participating in the change management approach to try and get an agreed shared vision; they saw that real need and the desire for change. I guess the important things from the UnitingCare Wesley Mission service provision was that they were the specialists that came in and were able to dispel an enormous amount of myth..including [dealing with] issues of disclosure in the workplace. **What we worked out and started to learn really fast was that, if we were able to respectfully disclose, with consumer consent, we could set up a really strong support system around that consumer and employer to make sure that we give that person every chance of genuine success in maintaining and sustaining their employment.**[242]

4.275 As with the Queensland model, teamwork is key. Mr Bamford elaborated:

> There is a relationship between the employment specialist and the mental health coordinator or the mental health specialist. When they are part of the same team....the relationship is ongoing and daily. That then overcomes the batching of all the big decisions to a three-monthly case conference or clinical review....There are multiple opportunities to influence that care plan.[243]

4.276 Also, like the Queensland model, the Southern Mental Health model has so far only dealt with and reached small numbers of people. Mr Strachan indicated that the potential is there to scale the model up and extend it to the far greater numbers of community-based clients who have a care plan but access it more infrequently:

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241 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 24.

242 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 25.

243 Mr Bamford, South Australia Health, *Committee Hansard*, 7 June 2011, p. 25.

> The potential is there. The desire is there. Our staff want it. Our staff keep asking for it. But it is capacity....[244]
>
> ...rolling it out to a community team with 500 consumers is taking a whole other journey.[245]

4.277 Mr Bamford intimated that this may not necessarily be a case of utilising further resources; existing ones may be sufficient. Nonetheless, an integrated model does require commitment and drive:

> ..for integration to happen, someone needs to support that integration – someone to actively support that change and then embed that change over time. John talked a bit about how they have done it with existing resources, and that is half a day a week from the employment specialist.[246]

4.278 The Committee can see the many benefits that a service model that integrates employment and clinical services can entail for the consumer but notes that to-date these have only operated on a small scale.

Recommendation 15

The Committee recommends that the Commonwealth Government explore ways, in partnership with the states and territories through COAG, to support Individual Support and Placement (ISP) and other service models that integrate employment services and clinical health services.

244 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 24.

245 Mr John Strachan, Acting Outer South Sector Manager, Southern Mental Health, Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 27.

246 Mr Bamford, , Adelaide Health Service, South Australia Health, *Committee Hansard*, 7 June 2011, p. 27.