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Presentation to the Australian Government's Parliamentary Inquiry into Mental Health and Workforce Participation

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Dr Geoff Waghorn Ph.D.[1,2,3]

1. Head of Social Inclusion and Translational Research, the Queensland Centre for Mental Health Research (QCMHR), Queensland Health; and
2. Adjunct Senior Lecturer, School of Population Health, University of Queensland, Brisbane, Australia.
3. Contact details: Dr Geoff Waghorn, Queensland Centre for Mental Health Research, The Park, Centre for Mental Health, Wacol, (via Brisbane) Queensland 4076, Australia.

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Increasing workforce participation among people with severe mental health conditions and psychiatric disabilities

This presentation concerns the employment aspect of the first term of reference:
1. *Barriers to participation in education, training and employment of people with mental ill health.*

Aims

1. It is not everyday that a researcher can report that a government program could be improved by a reduction in funding. This presentation briefly examines the performance of the national network of disability employment services (DES) over the past 10 years, and explores possible reasons for its recent rapid decline. This performance decline has now become the greatest barrier for Australians of working age with mental illness. It is more important than the economy, attitudes of employers, and even the disabilities caused by severe mental illness. This presentation explores this issue further and suggests how the current system can be reformed to achieve more acceptable employment outcomes for working age Australians with severe and persistent mental illnesses.

Background

2. Mental illness and psychiatric disability at an individual level disrupt schooling, school to work transitions, employment, and pathways to a career, both directly and indirectly (see Waghorn & Lloyd 2005). For instance, in an ABS population survey in Australia in 2003 (Waghorn et al, 2009) only 16% of working age community residents with schizophrenia were employed despite 2003 being a year of high labour demand. Research evidence over the past 20 years (Bond 2004; Bond et al, 2008) has shown that it is not client characteristics, or even labour market characteristics, that mostly predict employment outcomes, but the characteristics of services and their practices. While client characteristics and labour market characteristics may influence service intensity and the cost of service provision, they do not predict employment outcomes in the presence of an effective employment service.

Widely available but ineffective services

3. Availability of services in Australia is no longer a barrier except in remote locations. Australia now has a multi-billion dollar disability employment industry consisting of Disability Employment Services (DES) contracted to DEEWR. These have evolved since being first established by the Disability Services Act, 1986; and are now guided by a comprehensive national strategy (Australian Government, 2009). The problem is that the effectiveness of these services has recently crashed. According to DEEWR's interim evaluation released in July 2011 (Table 3.3, p 31), only 10.6% of clients with a primary psychiatric disability, at funding level 2, achieved 13 weeks of employment or an education pathway outcome during March to December 2010. This result is less than the program achieved in 2007 where 43% of clients with psychiatric disability attained the 13 week milestone. DES performance, in terms of 13 week outcomes, has fallen from 43% to 17% in 2009 and to 10-14% in 2010 (see Table 1, DEEWR 2007; 2011).

4. Meanwhile, the proportion of clients with a primary disability of psychiatric increased from 24% in the Block Grant Funding model, peaking at 36% in the Case Based Funding model 2005, and eased back to 31.2% in the DES model. Clients with psychiatric disability are

currently in the second largest proportion (following physical and mixed disabilities) yet continue to have among the poorest employment outcomes.

Table 1. Disability employment services official outcomes 2002-2010.

Program name	Data collection	Cohort (new clients)	Employment outcomes			
			Psychiatric Disability (Primary)		All disability categories	
			Proportion attaining 13 weeks employment (%)	Proportion attaining 26 weeks employment (%)	Proportion attaining 13 weeks employment (%)	Proportion attaining 26 weeks employment (%)
Block Grant Funding[1]	24 months prior to 2005	na	na	na	25.0	na
Case Based Funding trial Phase 1[1]	18 months Nov 1999 to June 2000	na	na	na	na	32.0
Case Based Funding trial Phase 2[1]	18 months Jan 2001 to June 2002	na	na	na	na	25.0
Case Based Funding model 2005[1]	24 months July 2005 to June 2007	7624	na	29.2	43.0	33.1
Disability Employment Network (Capped)[2]	18 months July 2005 to Dec 2006	37606	na	na	31.8	25.0
Disability Employment Network[1]	18 months June 2006 to Dec 2007	6750	43.3	34.0	48.5 (other than psychiatric disability)	40.1 (other than psychiatric disability)
Disability Employment Network[3]	9 months Mar 2009 to Dec 2009	4487	17.0	na	14.1	na
Disability Employment Services (ESS Funding Level 1)[3]	9 months Mar 2010 to Dec 2010	2831	14.2	na	14.8	na
Disability Employment Services (ESS Funding Level 2)[3]	9 months Mar 2010 to Dec 2010	1333	10.6	na	12.4	na
Disability Employment Services (ESS overall)[3]	9 months Mar 2010 to Dec 2010	4164	14.0	na	14.0	na

Notes: na = data not available. All statistics shown are from official reports (1 DEEWR 2007; 2 SA Centre for Economic Studies, 2007; 3 DEEWR 2011).

5. This evidence suggests that declining DES performance now represents the greatest barrier to employment for Australian community residents with severe mental illness and psychiatric disabilities. Although there have been positive enhancements to the program since 1986 (such as uncapping of program places, Australian Government 2009), other changes since December 2007 now seem counter-productive. The program could now be so inefficient for people with psychiatric disabilities that it may represent a zero net effect. The evidence for this is that Australian population surveys (Waghorn et al, 2009) show that at any time about 16-19% of people with schizophrenia and other severe mental illnesses, are employed and do not report receiving employment assistance.

Reasons for declining DES performance

6. Our work (Browne et al, 2009; Waghorn et al, 2011; Waghorn et al, in press) suggests the most likely candidate is a failure of the majority of DES providers to adopt the evidence-based practices shown to be the most effective in international trials. We suspect this because when we have helped services in Australia and in NZ to replace traditional vocational services with more evidence-based practices, to high levels of fidelity, performance typically increases to around 70% or more obtaining employment, and over 40% attaining the 26 weeks employment milestone. In summary, applying evidence-based practices enables more challenging clients to access the program, and instead of this causing performance to decrease as services usually expect, performance typically increases four-fold within 6-12 months as service capability increases.

7. If the DES contract and star rating system reward performance as so repeatedly claimed by program administrators, *why do so few services attempt to implement evidence-based practices?* Anecdotally, we think there are several reasons:

a. **The current funding structure rewards high caseloads** (inputs) ahead of client outcomes (outputs). For instance, a caseload of 50 funding level 2 clients in DES Employment Support Services (ESS) over two years generates $760,000 in service fees alone, which represents over 5 times the bi-annual salary (including on-costs) of one full-time equivalent employment consultant. This is what the service would earn if no clients got a job. These returns drive caseloads in the opposite direction to that required by evidence-based practices.

b. **The current funding structure rewards low intensity of services**. Over $15,000 per participant in service fees could be removed immediately from this program and the result would only be better for both clients and the taxpayer. Service would then have to increase their employment outcomes to increase revenue, and would not be perversely encouraged to reduce the intensity of services. International research shows that expected outcomes are rarely achieved when caseloads exceed 25 active clients. At higher caseloads of 26-50 clients 1/4 to 1/3 may still get jobs, but job retention typically decreases, and many clients that get jobs, do so without help. DEEWR's evaluation (Table 3.4.1, 2007) confirms the negative relationship between caseload size and employment outcomes.

c. **The star-rating system benchmarks to average DES performance, not to fixed benchmarks of expected performance.** This allows all services to drift towards low outcomes, while maintaining their relative performance, and hence their star rating. The modelling results reported (SACES, 2007)show that 95.1% of the variance in DES 26 week outcomes is not explained by client or labour market characteristics. Hence the model does not predict performance on the highest weighted primary outcome variable. Therefore a better approach would be to anchor the star rating system to a fixed level of expected performance based on high quality international studies. This would then enable all services to achieve five star ratings on objective indicators, without limiting their success to one tail of a normal

distribution. This approach would also reduce excessive competition among providers by encouraging all services to share practices that achieve these results. Their success would then no longer be contingent on the failure of other providers.

d. **The regression modelling accounts for less than 5% of the highest value employment outcome.** The regression modelling used to generate and justify the DES star rating system, actually models client characteristics and labour market characteristics, not provider characteristics. Consequently, as expected, it only explains 4.9% of the variance in 26 week employment outcomes (SACES, 2007, p.27). This is in line with international evidence, that client characteristics are not predictive, and that such modelling can do little more than adjust for these minor client differences. Raw outcomes on each KPI outcome variable for a relevant client mix, are therefore more likely to guide service providers. E.g. specialist providers could be benchmarked to expected outcomes for their specialty clients, with a small composite 'adjustment factor' based on actual client characteristics (of those that obtained employment) and local labour market features, limited to less than 5% of raw performance scores.

e. **Volunteers are increasingly displaced by conscripts.** Changes to Disability Support Pension (DSP) eligibility and increased mutual obligations for other benefit types have resulted in more clients being conscripted to DES. The evidence-based practices identified (Bond, 2004; Bond et al, 2008) apply to volunteers not conscripts and we know little about how best to assist conscripts. The sudden increase in the proportion of non-volunteers entering the program may have contributed to the sudden decline in performance from 2007 to 2009. Perhaps this is because practices for conscripts are less intensive with lower outcome expectations than for volunteers. The resulting combination of lower client motivation and lower service intensity may account for the poorer employment outcomes.

f. **The instability of DES program parameters.** DEEWR staff are constantly revising the program, rewriting the contract, and replacing or changing the formal administration and online system requirements. These changes have not improved performance. The current DES deed is 155 pages in length. As shown in Table 1, the program has been renamed six times in six years. Whenever this happens the impact on services is high, particularly on smaller providers. Each time the program is revised, more complex elements are added so that the program becomes more costly to administer at both DEEWR and provider levels. Fortunately some elements were simplified (e.g. funding levels) in the most recent revision. These frequent program changes engage DES providers more in contract management activity than in the implementation and monitoring of evidence-based practices.

Other issues

8. **Unknown validity of program eligibility and funding level classifications.** Providers often report difficulties getting clients with mental illness and psychiatric disability correctly classified as eligible to receive a DES service, and then classified at the correct funding level to make an intensive service viable. A common problem reported is that of a Job Capacity Assessor (JCA) classifying a client as only able to benefit from sheltered employment (capable of less than 8 hours per week), which denies access to DES even when open employment is the client's explicit goal. While challenging unfair JCA decisions is possible, it takes time and clashes with the evidence-based principle of providing services rapidly in response to client preferences. Given that clients on Sickness Allowance and DSP are the priority target group, why not exempt these volunteers from the Job Capacity Assessment altogether? This could reduce the delay to commencing employment by about 4 weeks. There is also much that could be done to investigate, report, and improve the utility, reliability, and validity of JCAs and funding level classifications, which are currently treated as if they are reliable, valid, optimal, and beyond question by industry.

9. **Evidence that wage subsidies are a waste of money.** The major 2011-2012 budget initiative was to introduce a costly 6-month wage subsidy which clashes with the international evidence. On DEEWR's own evidence (DEEWR 2007, Table 3.7.1) wage subsidies are unlikely to improve real employment outcomes, because conversion rates don't improve. The subsidies will however, confound and inflate 26 week employment outcomes because some of these jobs will only be retained while the subsidy applies, and would not otherwise convert to 26 weeks of competitive employment.

10. **Unnecessary program complexity.** The two branches of the program, ESS and Disability Management Services (DMS), need to be urgently amalgamated so that clients can access a wider range of services. The only difference in real terms is that DMS clients can only receive level one funding, and are supposed to have a shorter period of post employment support needs. However, the JCA process will never (see Waghorn & Lloyd, 2005 for a summary of the evidence against such methods) sufficiently accurately classify, predict funding level, or predict post employment support needs. Hence it would be more realistic to combine these two programs into one, and allow funding level one clients to chose from among ESS and DMS providers.

11. **Market share rules restrict client access.** While volunteers have a choice of service providers, conscripts are allocated to service providers by Centrelink. This means that the more effective services are unable to grow their client inputs in competition with other local providers. While market share rules have a place in some regions, in other areas they are a barrier to service development. All clients should have the right to choose service providers whether they have activity obligations or not.

12. **Total program costs remain unreported.** To our knowledge, the total cost of the DES program and its administration remain unreported. Although DEEWR report contract expenditure, they do not report the total cost of program governance, administration (salaries of all DEEWR and Centrelink staff) and all program related expenditure. Once synthesised, this information would set the baseline for improving program cost-effectiveness, and could be used to plan reductions in the adverse impacts of program over-administration on service providers. There are two ways to improve program cost-effectiveness: (1) reduce the total program costs per employment outcome; and (2) improve program efficiency (e.g. the ratio of 26-week employment outcomes to the total number of clients entering the program).

Summary

13. The most substantial barrier to participation in competitive employment for Australians with mental ill health is the declining DES performance. This appears to be due to funding disincentives and a star rating system which obscures rather than elucidates reasons for high and low performance. The DES program urgently needs stability, streamlined administration, and greater incentives for providers to adopt evidence-based practices. Particularly for clients with mental health conditions or psychiatric disabilities.

14. In the meantime, one way to begin reversing this decline is to only purchase program outputs and cease purchasing program inputs. This can be done by removing the quarterly service fees which are paid for all clients who achieve nothing more than remaining 'on the books'. The extensive savings that result could further support the implementation of evidence based practices as identified by work at QCMHR and in high quality international trials.

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