CHAPTER 10

SUPPORT SERVICES FOR PEOPLE FACING MENTAL HEALTH PROBLEMS

Introduction

10.1   Health and wellbeing are influenced by experiences and opportunities in many intersecting areas of life. For people experiencing mental health problems, community-based treatment is not only about 'health' services but is intrinsically linked to supports and services in other spheres of life:

> I as a carer on occasions have been very disappointed by what I felt was a lack of support. But is it wrong to expect the very best of care for my son when he leaves hospital? Is it wrong to expect he should be able to live independently which from all accounts would be better for him and his illness? Is it wrong to expect he should be able to work so he could regain his self-esteem and confidence again so he can feel he is a normal part of society? I have watched him try and try to just regain his life to just have a small part of what he had back.[1]

10.2   Submissions to the inquiry emphasised that mental health services need to operate within an integrated framework which links related human services such as housing, employment, training, rehabilitation and disability supports.[2] The National Mental Health Plan 2003-2008 acknowledged this need:

> Improving the mental health of Australians cannot be achieved within the health sector alone. A whole-of-government approach is required which brings together a range of sectors that impact on the mental health of individuals, such as housing, education, welfare and justice.[3]

10.3   Evidence to the inquiry canvassed some of the innovative programs that assist people experiencing mental illness, in areas beyond the 'health' system, such as housing, employment and training and on the essential role non-government organisations (NGO) play in providing these services.

10.4   There are significant service gaps, that result in poverty and homelessness and, where services are available, lack of integration remains a significant barrier to the health and wellbeing of people with mental illness. Numerous submissions to the inquiry called for increased linkages and integration across service sectors.[4]

---

1   Name withheld, *Submission 123,* p. 2.

2   See for example, Mental Health Council of Australia, *Submission 262*, p. 7; Queensland Alliance, *Submission 288;* Public Interest Law Clearing House (PILCH) Homeless Persons' Legal Clinic, *Submission 41*; Australian Council of Social Services, *Submission 457*; Professor Ian Webster *Submission 458*, p. 33; Mission Australia, *Submission 199*

3   Australian Health Ministers, *National Mental Health Plan 2003-2008*, 2003, p. 13.

4   See for example, Mental Health Council of Australia, *Submission 262;* Australian Council of Social Services, *Submission 457*; Mission Australia, *Submission 199.*

10.5   This chapter provides a brief overview of access to mainstream support services including accommodation, employment and training, and income support and describes some successful programs.

10.6   This chapter does not detail all the funding streams and available programs provided by federal, state and territory governments, but refers interested readers to the relevant submissions for details.

Accessing mainstream services

10.7   The Australian Government submitted that:

> A range of mainstream programs and services are also provided by the Australian Government which provide essential support for people with a mental illness. These include income support, social and community services, disability programs, and housing assistance programs.[5]
> For every dollar spent by the Australian Government on specific mental health services, an additional $3.20 is spent on providing community and income support services to assist people with mental illnesses.[6]

10.8   The Commonwealth did not indicate whether this expenditure on support services was higher for those with mental illness than for welfare recipients in general, although it might be expected that the former would have greater welfare needs. The Mental Health Council of Australia (MHCA) stated that generalist housing, education and employment services are reluctant to provide services to mental health consumers without additional support, and there is inadequate funding for these services to help consumers and their carers.[7] They also argued that:

> The lack of concrete data about actual service provision, and more importantly, consumers' access to mainstream health, housing, employment, education and social activities is a distinct weakness in the National Mental Health Strategy.[8]

10.9   There is a lack of integration and coordination across service sectors and difficulties with eligibility requirements for specific programs and services. A strong need is identified for consumer-operated services and increased training and education in mental health.

Lack of integration

10.10   Formal pathways between services are 'virtually non-existent', with a lack of formal supports, agreements or protocols between services:

---

5   Australian Government, *Submission 476,* p. 1.

6   Australian Government, *Submission 476,* p. 4.

7   Mental Health Council of Australia, *Submission 262*

8   Mental Health Council of Australia, *Submission 262,* p. 10.

> Individual case managers are left to argue the rights and wrongs of an individual's access to services which, in a well-run system, would be automatic.[9]

10.11　Hanover Welfare Services called for a collaborative approach, and argued that cost savings could be made by restructuring and rationalising the 'current fragmented and silo based programs' into an integrated package of assistance.[10] Submitters called for effective leadership and governance arrangements to ensure that integrated services operate effectively. The Mental Health Association NSW Inc. suggested that programs 'must be whole of government, and controlled by an inter-government/NGO advisory group'.[11]

10.12　For inter-agency integration to work there needs to be a culture change:

> Opportunities for coordination of services would be greatly facilitated by better communication, sharing of information and breaking down of inter-agency "territorialism". There are significant barriers to the coordination of clinical and so called non-clinical or rehabilitation services that seem to be borne out of professional jealousy, ignorance or disrespect. This results in gaps in services to clients due to one service provider either not knowing what other services are available and/or a service provider believing (wrongly) that a service is being provided by another agency.[12]

10.13　Hanover reported on research examining services for women with complex needs that found it was important to locate mental health service expertise within other services, such as housing services, rather than referring consumers elsewhere. Hanover also commented that, at the least, involving support workers in the referral process was helpful as someone in poor mental health may not be in a position to effectively relay sufficient information to other service providers.[13]

10.14　The Department of Families, Community Services and Indigenous Affairs acknowledged the need for integration of services and pointed to some of the issues:

> One of the biggest barriers is privacy. You cannot share information. Another barrier is that the different systems do not talk to each other: IT does not talk to each other, so DEWR's system does not talk to Centrelink's system. There are those sorts of issues. If you try to deliver a number of programs through one case manager, each program's funding has to be kept separate and delivered separately. There are all sorts of barriers. FACS(IA) is now convening an IDC to start to work through some of those barriers to make joined-up service delivery more of a reality for the homeless and people who have complex needs.[14]

9　　Mental Health Council of Australia, *Submission 262,* p. 17.

10　Hanover Welfare Services, *Submission 403,* p. 18.

11　Mental Health Association NSW Inc, *Submission 230,* p. 9.

12　Name withheld, *Submission 244*, p. 5.

13　*Submission 403,* p. 7.

14　Ms Ellen Wood, Section Manager, Homeless Policy and Assistance, FaCSIA, *Committee Hansard,* 7 October 2005, p. 91.

10.15   The lack of integration and coordination between mental health and alcohol and drug services was a major issue raised and is discussed in Chapter 14.

Training and education for service staff

10.16   A lack of understanding about mental health can lead to mainstream service providers excluding people with mental illness:

> Generally there exists a poor level of knowledge and skills amongst staff within both government and non government (non mental health) services (housing, employment, law enforcement, and community development)… Training and consultation programmes are required to assist develop knowledge and capacity within these agencies.[15]
>
> Even where a consumer, carer or support service is able to access other community services, their problems are not over. The [National Mental Health] Strategy does not make adequate provision for funding education and training to enable staff in other health and community sector services to work effectively with mental health consumers. Having won the lottery of access to appropriate support, consumers often find continuing difficulty in dealing with service providers who are untrained in dealing with people with mental illness.[16]

10.17   ACROD, the National Industry Association for Disability Services, argued that significantly greater knowledge transfer among all service providers is necessary to improve service integration:

> In policy terms, this is a long-term goal which will most effectively be achieved by a revision in the training of all services. Put bluntly, it will not be a question of the occasional inter-agency workshop, but an overhaul of personnel training in which, for example, there is more accredited multi-disciplinary training…at an acceptably high level.[17]

Service eligibility requirements

10.18   The requirement that consumers must have a documented diagnosis to be eligible for services creates difficulties:

> …in order to access a range of programs and/or assistance, a diagnosis is an essential pre-requisite. A concrete example of this is the Youth Residential Rehabilitation Program funded by the State Government, where to be eligible for housing, the person must have a serious mental illness diagnosis. Similarly, people cannot access other specialist services without a diagnosis.[18]

10.19   Diagnosis can be difficult, inaccurate and time consuming, or may be extremely challenging to obtain for people who have limited – if any – contact with

---

15   Western Australian Child and Adolescent Mental Health Services Advisory Committee, *Submission 24*, [p.] 9.

16   Mental Health Council of Australia, *Submission 262,*p. 18.

17   ACROD, *Submission 335*, p. 12.

18   Catholic Social Services Victoria, *Submission 381,* p. 7.

the health system. People who are homeless or transient often do not have proof of identity or a Medicare card, let alone suitable documentation of a diagnosis.

10.20   Divulging a diagnosis, given the stigma associated with mental illness and real possibility of discrimination, can also be a problem.[19]

Need for consumer-run services

10.21   Submissions emphasised the importance of consumer-run services, and consumer representation on policy formation and advisory committees:

> There remains a severe shortage of community support services, especially those which are consumer initiated and managed, including housing, home help, recreation, family support, employment and education options for people with a mental illness and their families.[20]

10.22   The Richmond Fellowship recommended seed grants for consumer run programs, particularly those run in partnership with larger service providers.[21] Further discussion of the importance of consumer participation in service delivery is provided in Chapter 3.

Accommodation

10.23   A fundamental requirement underlying the policy of community-based care and treatment for people experiencing mental illness is the need for appropriate accommodation. In 1993, the Burdekin Report assessed that the 'absence of suitable supported accommodation is the single biggest obstacle to recovery and effective rehabilitation'.[22] Deinstitutionalisation moved thousands of people out of institutions and into the community, but without a commensurate growth in accommodation. People with mental health problems are not homogenous and along with extreme shortages of short, medium and long term accommodation, the diversity of needs is not being met.

> The only way that I could eventually find security of accommodation for my son was to use a small life insurance payout to put a deposit on a house for him eleven years ago, and to assist him since then with mortgage payments. Previous to that time he had lived with relatives, friends, a privately run sub-standard boarding house, and a small caravan in a caravan park from where he was evicted and sent to hospital on an involuntary order. He then began living in rental properties but all of these were eventually put up for sale and he had to move on. The stress of continually

---

19   *Submission 381,* p. 17.

20   ACOSS, *Submission 457,* p. 17.

21   The Richmond Fellowship of Australia, *Submission 234*, p. 5.

22   Human Rights and Equal Opportunity Commission, Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness, AGPS, Canberra, 1993, p. 919.

> moving and trying to find accommodation resulted in the deterioration of my son's mental health, often significantly.[23]

10.24   Shelter and housing are basic human needs. Article 11 of the *International Covenant on Economic, Social and Cultural Rights* provides that all people have the right to adequate housing.[24] Suitable accommodation is critical for several fundamental reasons. Firstly, it is an effective and cost-efficient preventative measure.[25] Secondly, without stable housing, people with mental illnesses experience more frequent and prolonged periods of illness and increased disability.[26]

Current accommodation services

10.25   Public and community housing and crisis accommodation are the responsibility of state and territory governments. The Australian Government has committed to contribute around $4.75 billion under the 2003-2008 Commonwealth-State Housing Agreement (CSHA), which sets the strategic directions for housing assistance.[27]

10.26   Public housing is the largest form of assistance provided under the CSHA and is available to people on low incomes and those with special needs. In 2001-02, 40.8 per cent of public housing allocations were to people with a disability. Public housing rents are usually set at market levels with rebates granted to low income tenants, so that they generally pay no more than 25 per cent of their assessable income in rent.[28] Community housing is 'rental housing provided for low to moderate income or special needs households managed by community-based organisations that are at least partly subsidised by government'.[29] Funding for community housing is typically either fully or partly provided by governments to not-for-profit organisations or local governments. Community housing models vary across jurisdictions.[30]

10.27   In addition to the CSHA, the Australian Government contributes funding to several other programs which may assist people with mental illness to obtain housing. These include Rent Assistance for income support recipients and low income families participating in the private rental market; the Home and Community Care Program, co-funded with the states to support people to live in their own homes; and the Supported Accommodation Assistance Program (SAAP).[31]

---

23   Name withheld, *Submission 124,* p. 2.

24   Public Interest Law Clearing House Homeless Persons' Legal Clinic, *Submission 41*, p. 7.

25   *Submission 41*, p. 7.

26   NSW Health – NSW Government, *Submission 470,* p. 33.

27   Australian Government, *Submission 476,* p. 47.

28   Australian Government, Productivity Commission, *Report on Government Services 2005*, p. 16.9

29   *Report on Government Services 2005*, p. 16.8.

30   Australian Government, Productivity Commission, *Report on Government Services 2005*, pp. 16.9–6.10.

31   Australian Government, *Submission 476,* pp. 47–48.

10.28   The SAAP provides funding for transitional accommodation and related support services for people who are homeless or at risk of homelessness. It is a cost shared program between the federal, and state and territory governments. Since its commencement in 1985, the SAAP has been implemented through five-year agreements between the governments.

10.29   The strategic directions for SAAP are subject to the Australian Government agreement, while the management and delivery of SAAP services are the responsibility of each state and territory government.[32] States and territories must 'plan, purchase or fund and develop services to meet agreed outcomes'.[33] Non-government agencies deliver most SAAP services, with some local government providers.[34]

10.30   The Department of Families, Community Services and Indigenous Affairs advised the committee that the most recent supported accommodation assistance agreement, signed in 2005, has a new strategic approach including the following elements:

- Early intervention and pre-crisis intervention – aiming to assist people before they lose their housing so they do not become homeless;

- Longer term support; and

- Better service delivery for people with high and complex needs, including more service linkages.[35]

10.31   They also noted that the new agreement includes an 'innovation and investment fund' to benchmark and disseminate best practice models of service throughout the program.

Accommodation issues

Homelessness

10.32   While it is extremely difficult to determine accurate prevalence rates of mental illness among the homeless, there are clear causal and consequential associations between the two. Studies indicate that between 30 and 80 per cent of people experiencing homelessness also experience mental disorders.[36]

---

32   *Submission 476,* Attachment 20, p. 2.

33   Supported Accommodation Assistance Program 2000-2005, Memorandum of Understanding, www.communities.qld.gov.au/community/homelessness/documents/pdf/mou_aug_1999.pdf (accessed December 2005).

34   *Report on Government Services 2005*, p. 15.40.

35   Ms Ellen Wood, Section Manager, Homeless Policy and Assistance, DFACS, *Committee Hansard,* 7 October 2005, pp. 92, 95.

36   See for example, Hanover Welfare Services, *Submission* 403, p. 2, Public Interest Law Clearing House (PILCH) Homeless Persons' Legal Clinic, *Submission 41*, p. 5; Professor Ian Webster, *Submission 458,* p.29; St Vincent de Paul Society, *Submission 478*, p. 3

10.33   Compared to the general population, there are significant barriers which make it very difficult for homeless people to access community services.[37] This includes: financial constraints; competing basic needs; a lack of transport; insufficient documentation, such as a Medicare card or proof-of-identity details; disconnection from support networks and assistance; the requirement to navigate a complex service system to access services; and discrimination, stigma and prejudice from some providers. They may also find it difficult to make and keep appointments. Problems may be further exacerbated if the person has co-morbid conditions, or has had a negative experience in the past.

10.34   Homeless people with mental illness are often left in situations further detrimental to their health. Staff of Hanover commented:

> Homeless people often end up in crowded low cost hotels and crisis accommodation services. These places have many different types of people and are often stressful environments. Drug dealing, assaults and theft are commonplaces. Clients who are trying to recover from depression or schizophrenia often find that their mental health suffers further because they are forced to live in inappropriate places.[38]

Accommodation supply

10.35   While real estate markets differ across regions it is the case that housing prices have risen 124 per cent over the period 1995 to 2005,[39] and there is an undersupply of low cost housing making it difficult for people with mental illness to access the private rental market. The Public Interest Law Clearing House (PILCH) Homeless Persons' Legal Clinic recognised that housing supply is influenced by a range of policies and argued for a 'National Housing and Taxation Plan' that includes strategies to align the supply of affordable housing with demand.[40] St Vincent de Paul called for a task force to investigate 'all aspects of the massive accommodation crisis'.[41] ACOSS said there is a 'chronic mismatch between housing supply and demand', and 'current policy settings are distorting both the home ownership and rental markets and effectively locking out low income earners'.[42]

10.36   While the CSHA now includes indexation, making funding for housing assistance more sustainable,[43] the base grant funding decreased by 54 over the last 10 years.[44] There has been some growth in supported housing and other targeted

---

37   Public Interest Law Clearing House (PILCH) Homeless Persons' Legal Clinic, *Submission 41*, p. 6.

38   Hanover Welfare Services, *Submission* 403, p. 17.

39   ABS, Cat. no. 6416.0, Table 10, *House Price Indexes, Established Houses - Index Numbers Quarterly*, September 2005.

40   Public Interest Law Clearing House Homeless Persons' Legal Clinic, *Submission 41*, p. 8.

41   St Vincent de Paul, *Submission 478,* p. 13.

42   ACOSS, *Submission 457,* p. 9.

43   2003 Commonwealth State Housing Agreement, Clause 4(6).

44   *Submission 457,* p. 9.

programs but the concurrent negligible increase in public housing stock and loss of low cost private housing options has resulted in overall reduction in affordable housing.[45] The Brotherhood of St Laurence argued:

> Public housing waiting lists are currently measured in terms of years, not months, with some consumers being told that they are unlikely to ever obtain a public housing unit. Private rental is one of their few options, but the cost of it leaves very little income on which to survive, even in rural and regional areas.[46]

10.37   One of the impacts of an undersupply of suitable accommodation for people with mental illness is an over reliance on inpatient services. A number of submissions indicated that many people currently in mental health inpatient care could be appropriately cared for in community settings if supports were available.[47] The Queensland Government stated that a lack of suitable accommodation and support was a key factor in preventing discharge.[48] In other cases, the undersupply of suitable accommodation results in people with mental illnesses being discharged onto the street, or into unsuitable accommodation.

Accommodation and support

10.38   Welfare organisations argued that there is a need for both increased affordable housing and for ongoing professional support:

> …a significant proportion of households under Segment One [highest priority public housing applicants] vacate their tenancies prematurely or involuntarily. One of the reasons for this loss of housing tenure is the lack of support to prevent vulnerability turning into crisis for individuals with complex issues, including psychiatric disorders.[49]

10.39   The Queensland Public Tenants Association Inc pointed to the unmet support needs of tenants with mental illnesses, observing that adverse outcomes occurred not only for those experiencing mental illness, but also their neighbours and the wider public housing system.[50] The Association commented:

> One tenant we are aware of lives in a 22 unit complex of public housing units in a major regional centre. Within that complex there are approximately five de-institutionalised mental health tenants. One of these tenants screams most of the time, including at night, making a good night's sleep a rare event. A second tenant calls emergency services to attend up to 5 or 6 times a day. …A third, a male tenant, frequently urinates in the open

---

45   Hanover Welfare Services, *Submission 403*, p. 18.

46   Brotherhood of St Laurence, *Submission 97*, p. 4.

47   NSW Health – NSW Government, *Submission 470,* p. 33; Queensland Government, *Submission 377*, p. 19.

48   Queensland Government, *Submission 377*, p. 19.

49   Hanover Welfare Services, *Submission 403*, p. 19.

50   Queensland Public Tenants Association Inc*, Submission 505*, p. 1.

garden area. And recently, one of our members walked out his front door and found his neighbour had hung himself off the balcony rails.[51]

10.40   The Association stated that more high needs tenants are entering into public housing without adequate support, and that Department of Housing struggles to manage these complex tenancies. The Association commented that there is a need for increased education and awareness to reduce the 'double-dose of stigmatisation' received by public housing tenants with mental illnesses, as well as increased coordination between levels of government and service providers to meet these tenants' support needs.[52]

Issues with SAAP

10.41   There is considerable unmet need for SAAP services. While on an average day 187 new clients are accommodated in SAAP, just over one in two new people seeking immediate accommodation are turned away. Turn away rates are highest for couples (with or without children), with 81 per cent of these people being turned away each day.[53]

10.42   A review by the NSW Ombudsman in 2004 found that people with mental illnesses were routinely excluded from SAAP services. Over half of SAAP agencies had policies that allowed people to be refused service on the basis of mental illness. There were 290 instances of people with a mental illness being denied access to services in a six month period.[54]

10.43   The Australian Government acknowledged the deficiency:

> Compared with other areas of expressed client needs, assistance with mental health disorders or mental illness has one of the highest levels of unmet need in the provision of SAAP services.[55]

Furthermore, as a transitional program, SAAP relies on other key programs to deliver essential services to homeless people.[56] The submission lists critical gaps in allied service systems which impact upon SAAP service delivery as:

- a crisis service which can respond to people with personality disorder and disordered behaviour, including those under the influence of drugs or alcohol;

- specialist services which can respond to homeless people with dual/multiple problems;

- health and mental health services which are appropriate for homeless people;

---

51   *Submission 505*, p. 3.

52   *Submission 505,* p. 1.

53   AIHW, *Demand for SAAP assistance by homeless people 2003-04, SAAP National Data Collection Agency Report Series 9*, p. 59.

54   NSW Ombudsman, 2004, *Summary report: Assisting homeless people – the need to improve their access to accommodation and support services*, p. 40.

55   Australian Government, *Submission 476,* Attachment 20, p. 2.

56   *Submission 476,* Attachment 20, p. 2.

- specialist and generic services which can respond to, or accommodate, people with disruptive behaviour; and

- ongoing support for people with high need to enable them to retain accommodation successfully in the community.[57]

10.44   The Queensland Government reported findings which 'indicate a growing concern among SAAP service providers about the increasing incidence of clients with high and complex needs who require support from services beyond SAAP'.[58] In many cases, SAAP agencies rated the prospect of obtaining assistance for these clients as 'poor' or 'nil'.[59]

10.45   A number of submissions to the inquiry advocated a substantial increase (in the order of 40 per cent) in funding to SAAP to service unmet need.[60]

Tenancies

10.46   The Combined Community Legal Centres' Group (NSW) Inc submitted that the expansion of 'good behaviour agreements' leaves people with mental illness vulnerable to eviction from public housing due to behaviour triggered by their illness. People have also been requested to give up their government housing while temporarily incapacitated in hospital. They recommended that good behaviour agreements be amended to accommodate the specific need of people with mental illnesses, and that Tenancy Acts be amended to place limitations on rent increases thus providing better security of tenure for people with mental illness.[61]

10.47   Residential Tenancy Databases are lists of tenants who real estate agents considered to be a tenancy risk and are used by agents to screen prospective tenants.[62] People with mental illnesses are vulnerable to being listed on these databases, limiting their ability to access rental accommodation. Furthermore, 'they may not be aware of the processes to remove their name or correct their listing or have the capacity to meet the various time limitations for action that could remove their name from the database'.[63] The Centre recommended that the Commonwealth should introduce a national system for the regulation of residential tenancy databases to alleviate misuse and abuse of these databases.[64]

---

57   *Submission 476,* Attachment 20, p. 4.

58   Queensland Health, *Submission 377*, p. 20.

59   *Submission 377*, p. 20.

60   For example: ACOSS*, Submission 457;* PILCH Homeless Persons' Legal Clinic; *Submission 41*.

61   Combined Community Legal Centres' Group (NSW) Inc. *Submission 232*

62   Senate Community Affairs References Committee*, Report on poverty and financial hardship*, March 2004, p. 138.

63   Combined Community Legal Centres' Group (NSW) Inc. *Submission 232,* p. 11.

64   *Submission 232,* p. 12.

10.48   The Centre drew attention to the need for adequate intervention and intensive support services to assist tenants with mental illnesses in dealing with landlords or resolving issues with neighbours, before problems escalate to eviction. They also advocated that a service should be established which monitors the progress of tenants with mental illnesses who are evicted from their homes.[65]

Respite accommodation

10.49   As discussed in Chapter 11 family members carry the large burden of care for people with mental illnesses, an arrangement that is cost-effective for government, but not sustainable without adequate support services, including respite accommodation.

10.50   Respite services are more likely to be available to frail, older people with physical disabilities or dementia than those with mental illness. Dr Yun-Hee Jeon submitted that there should be increased resources and flexible respite services for people with mental illnesses, as well as better increased promotion and awareness to over to overcome current problems in the system:

> …inadequate resource allocation to respite care services; health professional and respite staff's lack of awareness about respite care services and access procedures; inadequate promotion of respite to family carers; staff's negative attitudes towards the needs and experiences of family carers of persons with severe mental illness; current service delivery models which are not always timely and flexible, needs-based or person-centred; and lack of collaboration in care provision.[66]

10.51   The St Vincent de Paul Society stressed that respite centres should not be in institutional settings, recommending provision within adequately resourced group homes in the community.[67]

Accommodation services – what works?

10.52   Consumer groups and peak bodies acknowledged as better practice a number of models for accommodation. The Housing and Support Initiative, *Project 300* and Shepparton Housing programs are examined below.

The Housing and Support Initiative

10.53   The Housing and Support Initiative (HASI) is a joint initiative between the NSW departments of Health and Housing and local NGOs. Stage one provided coordinated disability support, accommodation and health services to people requiring high-level support to live in the community. A 12-month trial in South Eastern Sydney showed a decrease in inpatient bed days for patients enrolled in HASI from 197 days to 32 days.[68]

---

65   *Submission 232,* p. 15.

66   Dr Yun-Hee Jeon, *Submission 25*, p.2.

67   St Vincent de Paul Society, *Submission 478*, p. 15.

68   NSW Health – NSW Government *Submission 470,* p. 33.

10.54   Stages one and two of HASI focussed on 578 people residing in public and community housing and $8 million has now been allocated to extend the program to 126 more people requiring medium to high level disability support in their homes.[69]

Project 300

10.55   The *Project 300* program assists consumers to move from psychiatric treatment and rehabilitation facilities to the community. The Queensland Government explained:

> The program provides housing, supported accommodation, community access to services and other supports. It operates through the collaborative efforts of disability, mental health and housing services. The *Project 300* model of support is unique, focusing on community integration and participation. It operates with the support of, but not within, a medical model… The success of the model is highlighted by reductions in the level of support required by many individuals as they recover and as informal support networks increase within their own community'.[70]

10.56   *Project 300* commenced in 1995 and aimed to provide sufficient resources in the same budget to three different departments, responsible for clinical mental health services, disability-housing and disability services, to assist 300 people.[71] Each was provided with a 'package', consisting of mental health services, disability support services and community housing. The 18 month evaluation reported:

> The service model demonstrated improved well being for people with significant disability. It showed that clinical, housing and disability support services can be brought together to meet the needs of this population. Eighteen months after discharge, individuals continued to demonstrate improvements in symptoms, clinical functioning and quality of life. Remarkably few disadvantages for the clients were identified. Only 3 of the 218 client discharged returned to long-term care.[72]

10.57   The cost of *Project 300* was also evaluated as 'considerably less expensive' than other alternatives, such as treatment in rehabilitation or community care units.[73] On average, clients cost around $68,900 per client per year, as compared with $85,770 in a community care unit, $90,880 in a rehabilitation unit and $159,500 in an acute care unit.[74] A follow up evaluation of the project is nearing completion.[75]

10.58   The Queensland Alliance said the participation of NGOs was integral to the success of *Project 300* and that the integrated service model underpinning the project

---

69   *Submission 470,* p. 33.

70   Queensland Government, *Submission 377a,* pp. 23-24.

71   Queensland Alliance, *Submission 288*, p 17.

72   *Submission 288*, Attachment Two ' Evaluation of 'Project 300', p. 17.

73   *Submission 288*, Attachment Two ' Evaluation of 'Project 300', p. 25.

74   *Submission 288*, Attachment Two ' Evaluation of 'Project 300', p. 25.

75   *Submission 288*, p. 1.

could be replicated to reduce the over-representation of people with mental illness in prisons and among the homeless.[76]

10.59   The MHCA also commented favourably on the integrated service models provided by *Project 300* and HASI:

> Project 300, HASI and other similar state and territory programs demonstrate that intersectoral support for people with mental illnesses is critical to their stabilisation and rehabilitation.[77]

Specialist Residential Rehabilitation

10.60   Committee members visited two programs in Shepparton, Victoria: the Specialist Residential Rehabilitation Program (SRRP) and the Prevention and Recovery Care project (PARC on Maude). The SRRP is an innovative housing project, developed through collaboration between the Goulburn Valley Area Mental Health Service and the Mental Illness Fellowship. The committee also heard from the Cairns District Health Service about a proposal to establish a similar project in that city.

10.61   Residential programs such as this aim to allow people with mental illness 'learn or relearn living skills' in a safe environment, with professional support.[78] The Cairns project outlined the approach as having these features:

- Services should be flexible, and program-based, not facility-based. Facilities provided are part of the program.
- The Program should be centred in the community, and link with natural community settings whenever possible.
- Operate within a rehabilitation framework that recognises participants potential for personal growth and the right to opportunities which support growth.[79]

10.62   These residential services aim to integrate all aspects of recovery-based care, including assistance with employment, and vocational training and education and involve cooperation of different services, and between the government and non-government sectors. Although formal evaluations were not complete, early indications were that this type of program was successful with consumers and cost effective. Residential services are discussed in more detail in Chapter 9.

Public housing protocols

10.63   A tenant driven initiative involving the Queensland Department of Housing and seven community-based organisations has established a set of formal protocols for complex tenancies:

---

76   *Submission 288*, p. 8.

77   Mental Health Council of Australia, *Submission 262,* p. 18.

78   Mental Illness Fellowship Victoria, Specialist Residential Rehabilitation Service (SRRP)and Prevention and Recovery Care (PARC on Maude), http://www.mifellowship.org/ProgramInfo/ResiRehabSRRP.htm, accessed January 2006.

79   Cairns District Health Service, Cairns Integrated Mental Health Residential Rehabilitation Service, *Additional Information Received 12*.

> The Protocol process begins with the area office of the Department of
> Housing, identifying an 'at risk' tenancy i.e. a tenant who is issued with a
> notice to remedy breach which threatens the sustainability of their tenancy.
> This tenant is then asked if they would agree to being referred to the
> network of supporting organisations for help. Of course, tenants retain their
> right to privacy, and have the right to refuse help. The network of
> organisations then provides the tenant and their family with the support
> necessary to resolve whatever issue is threatening their tenancy.[80]

10.64   The Queensland Public Tenants Association reported 'an 80 per cent reduction in evictions from public housing over a two year period' following adoption of the protocols.[81]

Employment and training

10.65   The strong correlation between mental illness and unemployment is well established.[82] The participation rate of people with mental illness in the workforce in Australia is low compared with the population in general, people with other disabilities and people with mental illness in other OECD countries.[83] The MHCA submitted that less than 30 per cent of people with a mental illness participate in the workforce, despite evidence that working is therapeutic.

10.66   A lack of employment options for people experiencing mental illness has significant financial and social impacts: lost income; reduced development opportunities, social interaction and networks; and feelings of self worth. The MHCA stated that 'it is an essential part of early intervention, primary and secondary care for people to maintain engagement with work if at all possible and to be able to achieve an orderly and successful return to work where their illness has required them to leave'.[84]

10.67   Supporting people with mental illness to participate in the workforce also has broader society-wide benefits through increased productivity and savings on income support payments and health services.[85]

Employment and training services

10.68   The Commonwealth State Territory Disability Agreement provides the national framework for the delivery, funding and development of specialist disability services. Under the agreement the Commonwealth has responsibility for specialised

---

80   Queensland Public Tenants Association, *Submission 505*, p. 5.

81   Queensland Public Tenants Association, *Submission 505*, p. 5.

82   See for example, Professor Ian Webster, *Submission 458,* p. 25.

83   Mental Health Council of Australia, *Promoting Supportive Workplaces for People with Mental Illness Employer Forums, Report to DEWR*, August 2005, p. 3.

84   Mental Health Council of Australia, *Submission 262,* p. 33.

85   Centre of Full Employment and Equity (CofFEE), *Submission 228,* p. 6.

employment assistance.[86] The Commonwealth also funds Job Network, Australia's mainstream employment assistance program.

Job Network

10.69   Job Network is a national network of community and private organisations contracted to find jobs for the unemployed. A general discussion of the history, role and effectiveness of the Job Network is provided in the Community Affairs References Committee report on poverty and financial hardship.[87] In summary the current Job Network has two major functions:

- Job search support – offering job search training programs; and

- Intensive support and customised assistance – the most personalised and intensive forms of assistance offered, including job search assistance, work experience, vocational training, language and literacy training and post placement support. Providers have access to a pool of funds, the 'job-seeker account', to purchase assistance to help eligible people into work.

10.70   A number of providers in the Job Network have specialist capabilities in working with job seekers with a disability or mental health problem.[88]

Targeted services

10.71   Two specialist services which may assist people with a mental illness into employment are the Disability Open Employment Services and the Personal Support Program. Disability Open Employment Services assists job seekers with disabilities who have significant or ongoing support needs, through training, job placement and on the job support.[89] The Australian Government advised that in 2003-04, Open Disability Employment Services helped 48,431 people with moderate to severe disabilities find and keep work, 24 per cent of whom had a psychiatric disability.[90]

10.72   The Personal Support Program (PSP) aims to bridge the gap between crisis assistance and employment assistance. The program is targeted at people receiving income support 'whose non-vocational barriers (such as homelessness, mental health problems or mental illness, drug or gambling problems or social isolation) prevent them from getting a job or benefiting from employment assistance services'.[91] The

---

86   Australian Government, *Submission 476, Attachment 10,* p. 1.

87   Senate Community Affairs References Committee, *A hand up not a hand out: Renewing the fight against poverty, Report on poverty and financial hardship* (hereafter 'Report on poverty and financial hardship') March 2004, pp 65-69.

88   Australian Government, *Submission 476*, Attachment 13, p. 1.

89   *Submission 476*, Attachment 13, p. 1.

90   *Submission 476*, Attachment 13, p. 1.

91   *Submission 476*, Attachment 13, p. 2.

Department of Workplace Relations advised that 46 per cent of participants have a mental health problem.[92]

10.73   PSP participants are identified by Centrelink and may access the program for up to two years. The program is delivered by a network of private and community organisations. Currently 142 organisations, covering 600 sites are funded to deliver services. Approximately 60 sites are registered as having a speciality in mental health.[93]

10.74   Services offered under the program include counselling and personal support, referral and advocacy, practical support, outreach activities and ongoing assessment. The Australian Government stated that 'while getting a job is the ultimate goal, the program recognises that this may not be possible for all people at all times. Social outcomes may be the first steps towards independence'.[94]

Vocational training

10.75   The Australian Government funds vocational rehabilitation through CRS Australia (previously Commonwealth Rehabilitation Services) and described their programs as 'tailored to individual needs and can include vocational assessment and counselling, job preparation, placement and training, injury management and workplace modifications'.[95] CRS Australia assists over 35,000 people annually, with 29 per cent having a mental health condition as their primary disability.[96]

Employer incentives

10.76   Financial incentives are available to employers who employ workers with disabilities through the Workplace Modifications Scheme, which reimburses employers for costs such as modifying the workplace or providing specialist equipment when employing people with disabilities, and the Wage Subsidy Scheme, which subsidises wages for people with disabilities entering work.[97] Funding under the Wage Subsidy Scheme is only available through Open Employment Services and CRS Australia. The wages of each eligible worker may be fully or partially subsidised up to 13 weeks of pay, to a maximum of $1500.[98]

---

92   Mr Barry Sandison, Acting Group Manager, Working Age Policy, DEWR, *Committee Hansard*, 7 October 2005, p. 81.

93   *Submission 476*, Attachment 13, p. 2.

94   Australian Government, www.workplace.gov.au/workplace/Category/SchemesInitiatives/PSP (accessed December 2005).

95   Australian Government, *Submission 476,* p. 43.

96   *Submission 476,* p. 43.

97   *Submission 476,* p. 44.

98   Australian Government, *Workplace Subsidy Scheme Guidelines,* www.jobable.gov.au/Files/Wage_Subsidy_Scheme_Guidelines_Jan_2005.pdf (accessed December 2005).

10.77 $1 million has been allocated to research into the area of mental health and income support, including the development of tools providing practical advice to employers about employing people with mental health problems.[99]

Employment and training issues

10.78   People with mental health problems can experience a range of difficulties in accessing and retaining meaningful work. The barriers include cognitive: perceptual and social impacts associated with the illness itself or with treatment; the potential impact on health and supplementary income benefits of returning to work; ignorance and stigma present in workplaces and among service providers; inadequacy of programs and training to assist people with mental illness into employment; and lack of suitably designed jobs.

Workplace stigma

10.79   Stigma is still a barrier to workplace participation:

> The stigma attached to mental illness is wide-spread in the work force. A person may have ample qualifications and work experience to be able to successfully undertake a position, but if mention is made of suffering from a mental illness, you can almost guarantee that the job will go to someone else. The only instance where this doesn't occur is in consumer based employment where a "living knowledge" of mental illness is sought to assist others learning about or living with mental illness. There are not very many of these jobs out there and employers need to be made aware that they are often passing up the most appropriate people for the job.[100]

10.80   Submissions called for better education about mental illness in the workplace:

> Supervisory staff, managers and employees in all workplaces, including insurers need more education and training about mental illness. This might decrease workplaces harassment of people with mental illness and reduce their feeling of alienation.[101]

10.81   The MHCA argued that addressing workplace stigma has been left out of the National Mental Health Strategy:

> By not addressing these issues (workplace stigma), the Strategy fails to provide pressure, impetus or leadership for the necessary changes in support services and the average workplace. It is an essential part of early intervention, primary and secondary care for people to maintain engagement with work if at all possible and to be able to achieve an orderly and successful return to work where their illness has required them to leave.[102]

10.82   MHCA recommended that simple and effective measures for improving workforce participation include 'targeted workplace support programs, workplace

---

99   *Submission 476,* p. 44.

100   Mill Park Family Support Group, *Submission 72,* p. 2.

101   Name withheld, *Submission 238*, p. 1.

102   MHCA, *Submission 262*, pp 32-33.

education initiatives, providing meaningful re-training and employment options and improving workplace practices'.[103]

10.83   Mr Geoff Wagorn and Mr Chris Lloyd argued that stigma can be counteracted through 'strategic disclosure to employers and to other third parties throughout vocational rehabilitation' by vocational professionals.[104] They also noted that the services of education and advocacy centres run by mental health consumer organisations are often overlooked in the workplace and can help to educate professionals and service providers.[105]

Limitations of employment services

Funding caps

10.84   The number of places available in the main specialist program of employment assistance for people with disabilities, Open Employment Services, is capped and, as stated by ACOSS, a relatively low proportion of disability pension recipients in Australia receive help with employment or training.[106] Australia's programs are not strong in this area by OECD standards.[107] Similarly, ACOSS noted that funding for Disability Employment Assistance and CRS Australia programs are capped and often have waiting lists.

10.85   Ms O'Toole, Manager of Advance Employment Inc (a Disability Open Employment Service provider) expressed frustration about the impact of funding caps:

> Our agency is capped at 78 …a drop in a very large pond. I consistently have a waiting list of 25 to 30 people. It is soul destroying for me because, for a number of people that come along, their needs are so great initially. Open employment down the track is definitely possible, but we do not receive enough funding to allow us to put the programs in place to assist these people to get to that place.[108]

10.86   Open employment providers have previously argued for the removal of the cap on the appropriation for open employment services.[109] The Australian

---

103   *Submission 262*, p. 33.

104   G. Waghorn and C. Lloyd, *The Employment of People with Mental Illness: A discussion document prepared for the Mental Illness Fellowship of Australia,* 2005: *Submission 253*, Attachment 1.

105   G. Waghorn and C. Lloyd, *The Employment of People with Mental Illness: A discussion document prepared for the Mental Illness Fellowship of Australia,* 2005: *Submission 253*, Attachment 1, p. 19.

106   ACOSS, *Submission 457*, p. 6.

107   *Transforming Disability into Ability*, OECD, 2003, pp.108–112.

108   Ms Catherine O'Toole, *Committee Hansard,* 5 August 2005, p. 23.

109   DEWR, *Report on the Next Steps for Disability Open Employment Services consultations,* February 2005, pp. 3–4.

Government indicated that changing the cap 'would be a major decision for Government and it is not being considered'.[110]

10.87   Although uncapped funding may not be feasible, periodic review of each provider's capacity may be appropriate. Ms O'Toole said:

> I could demonstrate quite clearly over the past 12 months what our waiting list has been. I could demonstrate clearly enough that we could have our outlet capacity increased from 78 to, say, 98, because I have had a consistent waiting list.
> …if we can demonstrate it…I think that is fair and reasonable. That allows another employment consultant to be employed to look after those people.[111]

Uncapped places

10.88   ACOSS argued that while places in the Job Network are not capped, the program is not properly resourced. The highest level of assistance with the Job Network is 'Customised Assistance', however, as ACOSS pointed out:

> …the amount available for each highly disadvantaged job seeker is only about $1,300. This won't buy much rehabilitation or training and people will not generally be eligible for this level of assistance until they have been with the Job Network provider for 12 months.[112]

10.89   Ms O'Toole also pointed out that while Disability Open Employment Service providers must be accredited against disability service standards, Job Network providers do not have to meet this requirement.

Targeted services

10.90   MHCA indicated that even more targeted assistance programs, like the PSP, are not producing effective outcomes and need to be better integrated with other services. Mr John Mendoza said:

> …in some way we have to better connect government programs and not have this shower head effect where people who are, say, on the PSP program for two years really do not have the economic means themselves, nor can the providers that are receiving that PSP change the circumstances for those people. So they simply remain maintained rather than having programs that can intervene effectively and change the circumstances.[113]

10.91   Mission Australia, a PSP provider, reported increasing numbers of clients in its programs with mental illnesses; anxiety disorders and depression the most common. They say there are systemic gaps in the programs for clients with mental illnesses, including: limited availability, accessibility and affordability of specialist services; a lack of supported accommodation, living skills services, education and

---

110   DEWR, *Next steps for disability open employment services, Questions and Answers,* 7 February 2005, p.7.

111   *Committee Hansard*, 5 August 2005, p. 26.

112   ACOSS, *Submission 457,* p. 7.

113   Mr John Mendoza, Mental Health Council of Australia, *Committee Hansard*, 28 October 2005, p. 89.

training, transport, employment and rehabilitation; and funding for medication and other needs. Some clients also did not want to continue with counselling, and some services refused to work with clients because of a history of violence.

10.92   Mission Australia commented that the most important strategy to improve PSP for people with mental illness is to increase funding for health services, including the provision of 'culturally appropriate services and services for survivors of child abuse', and increased access to health care providers who bulk bill.[114]

10.93   Other suggestions include: more holistic service delivery; free training in mental health for service providers; more supported accommodation and employment options; small group programs, including life skills and personal development; more sustained follow up of clients; and recruitment of specialist volunteers to provide additional support to people with mental illness.[115]

Employer incentives

10.94   While the Australian Government noted that the Workplace Modifications Scheme and Wage Subsidy Schemes are financial incentives for employers who employ people with disabilities, reviews suggest that these programs are not used widely to assist people with *mental* illness. A review by the Department of Families, Community Services and Indigenous Affairs showed that from 1998 to 2002, the Workplace Modifications Scheme was most commonly used to assist employees with a visual impairment (37 per cent of approved applications) and employees with a physical disability (33 per cent). Similarly, information about the Wage Subsidy Scheme for 1998 to 2000 shows that most assisted workers had an intellectual disability (42 per cent), with only around 16 per cent of those assisted having psychiatric disabilities.[116]

10.95   MHCA suggested employer incentive schemes are not adequately promoted. Employer forums reported:

> There were calls for greater financial support to employers for the provision of workplace modifications for people with mental illness. This includes financial support to enable more flexibility in terms of hours worked, timing of work and workload and the provision of mental health services for those employees requiring ongoing assistance in the workplace. The current workplace modification schemes were virtually unknown and seen as overly narrow in scope.[117]

Employment service providers

---

114   Mission Australia, *Submission 199*, p. 5.

115   Mission Australia, *Submission 199*, p. 6.

116   Department of Families, Community Services and Indigenous Affairs, *Improving Employment Opportunities for People with a Disability, Report of the Review of the Employer Incentives Strategy*, March 2003, pp. 19–20.

117   Mental Health Council of Australia, *Promoting Supportive Workplaces for People with Mental Illness Employer Forums, Report to DEWR*, August 2005, p. 10.

10.96   ACROD, the National Industry Association for Disability Services, observed that the *episodic* nature of mental illness poses particular problems for employment services. ACROD said that the results-based accountability and performance reporting set in employment providers' service agreements may not adequately reflect the reality of service provision for people with mental illnesses:

> The requisite benchmarks, milestones or performance indicators cannot be predicted or met as readily as in the case of people with physical or intellectual disabilities.[118]

10.97   ACROD also submitted that employment services need to provide varied levels of support over time in accordance with a person's state of mental health. Therefore, the episodic nature of mental illness results in greater levels of personalised support, without additional funding necessarily being available. ACROD summarised that such difficulties create 'a perverse incentive not to take on clients with mental health problems'.[119]

10.98   Some of these difficulties are demonstrated in the following case study:

> J is a 32-year-old male with bipolar disorder. He gained a job through a disability employment service provider, working continuously for 24 weeks. A fortnight before the 26 weeks of work needed for a Case Based Funding (CBF) Worker Outcome he again became seriously ill. J lost his job and was suspended from CBF for three months.
> The employment agency tried to get J a case manager with the local Community Mental Health team when some of the early warning signs of his illness became apparent. Community Mental Health did not consider J to be a high need case, so no manager was assigned. His condition worsened to the point where he agreed voluntarily to go to intake (crisis care). The employment service had to accompany J to make sure he got there safely, the only alternative being to call the police. J was immediately admitted to hospital, remaining there for six weeks. During this time he lost his private accommodation.
> It was only because of his critical illness that J was able to obtain mental health support. But by this time it was too late to stop him losing his job and his accommodation.[120]

Emerging service models

10.99   Research into the effectiveness of vocational rehabilitation for people with mental illness is moving away from comparisons across services, to focus on the key characteristics underpinning successful vocational rehabilitation.[121] Evidence from controlled trials supports seven key principles for mental health vocational rehabilitation. The principles are:

---

118   ACROD, *Submission 335*, p. 8.

119   ACROD, *Submission 335*, p. 8.

120   *Submission 335*, p. 6.

121   G. Waghorn and C. Lloyd, *The Employment of People with Mental Illness: A discussion document prepared for the Mental Illness Fellowship of Australia,* 2005: *Submission 253*, attachment 1, p. 30.

- Eligibility for services is based on consumer choice – no attempt is made to screen out participants;

- Vocational rehabilitation is integrated with mental health care;

- A goal of competitive, mainstream employment;

- Rapid commencement of job search activities;

- Services are based on consumer preferences, strengths, prior work experience and interests, rather than on a pool of available jobs;

- Continuing support to retain employment – with no end date;

- Income support and benefits counselling – to help consumers make well informed decisions about their entitlements.[122]

10.100 Following a review of current services, a further four principles were identified:

- Intensive on-site support;

- A multidisciplinary team approach;

- Emphasis on the 'rehabilitation alliance' (a shared understanding of the staff member's and consumer's roles in rehabilitation); and

- Explicit stigma and disclosure strategies.

10.101 No Australian service meets all the above principles, with Disability Open Employment Services and CRS Australia Services rating the highest. Aspects commonly missing from Australian services include: integrating vocational rehabilitation and mental health care; providing intensive on-site support; using multidisciplinary teams, and incorporating strategies for countering stigma and managing disclosure.[123] Mr Geoff Waghorn argued that pooling mental health knowledge and expertise with vocational expertise is a key element that could be achieved quickly in Australia.[124]

Labour demand

10.102 The Centre of Full Employment and Equity (CofFEE) submitted that Commonwealth employment programs have focussed heavily on labour supply, without addressing the concurrent issue of labour demand. CofFEE argued that there are two related problems:

---

122 G. Waghorn and C. Lloyd, *The Employment of People with Mental Illness: A discussion document prepared for the Mental Illness Fellowship of Australia,* 2005: *Submission 253*, Attachment 1, pp. 30–31; Professor Bond, *Committee Hansard*, 19 May 2005, pp. 78–81.

123 G. Waghorn and C. Lloyd, *The Employment of People with Mental Illness: A discussion document prepared for the Mental Illness Fellowship of Australia,* 2005: *Submission 253*, Attachment 1, p. 34.

124 Mr Geoff Waghorn, Research Scientist, Queensland Centre for Mental Health Research and Mental Illness Fellowship of Australia, *Committee Hansard,* 19 May 2005, p. 89.

(a) a demand-deficient labour market excludes a disproportionate number of people with mental illness by placing them at the bottom of the queue awaiting work; and

(b) the design of available jobs may be inappropriate for those experiencing episodic illness.[125]

10.103 CofFEE advocated the introduction of a Job Guarantee for people with mental disorders. Under this model the federal government would provide an adequate number of Job Guarantee jobs, with positions flexibly designed to meet the varied support needs or workers with a mental illness:

> Under the JG, the Federal government would maintain a 'buffer stock' of minimum wage, public sector jobs to provide secure paid employment for disadvantaged citizens. The pool of JG workers would expand when the level of private sector activity falls and contract when private demand for labour rises.[126]

10.104 The Job Guarantee model would enable employers to hire from a pool of people with mental health conditions who are already working and maintaining essential labour market skills, rather than hiring from a pool of people who have experienced long-term unemployment or long-term dependence on the Disability Support Pension.[127] At the same time, CofFEE submitted that Job Guarantee jobs would be designed to accommodate the needs of those with episodic illnesses and be integrated with medical, rehabilitation and support services.[128]

10.105 The MHCA also commented on the impacts of the changing nature of the labour market, noting that demand for skilled labour and employment in the service sector has increased, while more traditional sectors such as manufacturing have declined. The Council observed that while employment flexibility in the form of part-time and casual employment has increased dramatically, 'mental health problems are more prevalent amongst those who have not benefited from the increased labour-force flexibility and have been excluded'.[129] The MHCA assessed that while employment has many benefits, jobs with high stress and low levels of control can have adverse consequences. The MHCA stated that 'Good job design can support the wellbeing of current and future employees, including those with pre-existing health needs be they physical or mental'.[130]

10.106 Submitters argued that open, competitive employment is an achievable aim as long as appropriate support is provided. Ms O'Toole emphasised the need for

---

125 CofFEE, *Submission 228,* p. 5.

126 CofFEE, *Submission 228,* p. 4.

127 *Submission 228,* p. 9.

128 *Submission 228*, p. 4.

129 Mental Health Council of Australia, *Promoting Supportive Workplaces for People with Mental Illness Employer Forums, Report to DEWR*, August 2005, p. 4.

130 Mental Health Council of Australia, *Promoting Supportive Workplaces for People with Mental Illness Employer Forums, Report to DEWR*, August 2005, p. 4.

employment providers to focus on what people can do, rather than what they cannot do:

> We believe that they can do what they want to do. I had a woman who came to me once and said, 'I am looking for a cleaning job'. She happened to have her resume with her, and she had university qualifications. She was an Indigenous person, and I said, 'I think you're going to be bored.' She said, 'No, I don't want anything with responsibility'. Well, she is now working in a government position. I did not go down the cleaning road. She was absolutely terrified, and with the right support and the talk with her and the building of her confidence and the belief in her, within three months she was working in a government department doing an excellent job. That is the stuff people need.[131]

Impacts on employment for carers

10.107 Many people with mental illnesses are dependent on family members for care and support, which in turn can impact on the ability of carers to participate in the labour market. In some cases carers either leave work or reduce their employment hours to support family members. Employment stress for carers can in turn impact on their financial and social wellbeing and that of their family.

> As for myself, I have had the privelege [sic] of having to abandon my job as a teacher, because there was simply no other way, to cope with the outcomes presented to relatives by this lunatic legislation [deinstitutionalisation]. I was a very good teacher of maths and science, and, what is more, enjoyed doing it very much – all my education and experience has been lost to both myself, and the community, and my role as a carer has ensured that I enjoy an old age of certain poverty – no superannuation for me![132]

> The suicidal tendencies had worsened and she was still heavily medicated. I was fortunate enough to obtain fulltime employment, with a very understanding organization, as I frequently had to take days off to rush her back to hospital when she suffered an episode and required hospitalisation. …I had to find full-time employment so that our family could continue to function and to enable our daughter to access a reasonable level of treatment.[133]

Education

10.108 While much of the evidence relating to education and training focussed on employment-related training, there is also a need to support people with mental health problems in mainstream education. The onset of some of the most severe mental disorders occurs in the teenage years and early twenties, at a time the completion of

---

131 Ms Catherine O'Toole, Manager, Advance Employment Inc., *Committee Hansard,* 5 August 2005, p. 27.

132 Name withheld, *Submission 518*, p. 2.

133 Name withheld, *Submission 208*, p. 5.

secondary and tertiary education is important and career pathways are being mapped, as is shown in research.[134]

10.109 In their discussion paper, Mr Geoff Waghorn and Mr Chris Lloyd argued that welfare, vocational rehabilitation and disability employment service reform in Australia throughout the 1990s addressed obtaining employment to the exclusion of higher education and substantive vocational training.[135] They argued:

> Specific strategies are needed to allocate responsibilities for the funding and delivery of disability-specific education assistance in primary, secondary, vocational, and higher education, over and above the generic assistance available to people with all categories of disability at education institutions.[136]

Income support

10.110 Mental illness can have a significant impact on people's income through disruptions to both employment and opportunities (such as education) which are instrumental to later career development. Reduced income limits the capacity of consumers to obtain the supports and services needed to manage their illness. As discussed in Chapter 6 the costs of mental health care are prohibitive for many people with mental illnesses.

10.111 ACOSS observed that all mental disorders are much more prevalent among income support recipients than non-recipients, with almost one in three income support recipients having a diagnosable mental disorder compared with one in five Australian adults not receiving income support.[137]

Income support services

10.112 The principal source of direct income support for people with a mental illness is the Australian Government's Disability Support Pension (DSP). At June 2004, one quarter of DSP recipients were people whose primary disability was a psychiatric or psychological condition. This was the second largest consumer group, behind those with musculo-skeletal and connective tissue conditions (34 per cent). In 2003-04, $1,903 million was provided through the DSP to people experiencing mental health conditions.[138]

10.113 Other income assistance includes:

---

134 Mr Geoff Waghorn, *Committee Hansard,* 19 May 2005, p. 83.

135 G. Waghorn and C. Lloyd, *The Employment of People with Mental Illness: A discussion document prepared for the Mental Illness Fellowship of Australia,* 2005: *Submission 253*, attachment 1, pp. 12, 37.

136 G. Waghorn and C. Lloyd, *The Employment of People with Mental Illness: A discussion document prepared for the Mental Illness Fellowship of Australia,* 2005: *Submission 253*, Attachment 1, p. 12.

137 ACOSS, *Submission 457*, p. 4.

138 Australian Government, *Submission 476,* pp. 39–41.

- Sickness Allowance – for eligible people who are temporarily unable to undertake their usual work or study due to illness or injury, and have a job or study to return to when they are fit;

- Newstart Allowance – for eligible unemployed people who are seeking paid work or undertaking other activities to improve their employment prospects;

- Youth Allowance – for eligible people aged 16-24 years who are engaged in activities such as education, training or job search that will to enhance their capacity for economic independence.[139]

10.114 People receiving DSP also receive the Pensioner Concession Card entitling them to concessions on prescription drugs through the Pharmaceutical Benefits Scheme.

Changes to income support payments

10.115 The legislative reforms announced in the 2005-06 budget and passed in December 2005 substantially change the operation of DSP. They also change the operation of Parenting Payments which may also be relevant to people with mental illness.

10.116 The Senate Community Affairs Legislation Committee in November 2005, inquired into the Employment and Workplace Relations Legislation Amendment (Welfare to Work and other Measures) Bill 2005 and Family and Community Services Legislation Amendment (Welfare to Work) Bill 2005.[140] A detailed examination of the changes and their anticipated impacts is not provided here, rather interested readers are referred to the committee's report.

10.117 Prior to these changes, eligibility for DSP was dependent upon the following:

> …a person must have a permanent physical, intellectual or psychiatric impairment of at least 20 points under the impairment tables. An impairment is defined as permanent if it is fully diagnosed, treated and stabilised and likely to last for at least two years without significant functional improvement. The person must also be unable to do any work for at least 30 hours a week at award wages, or be reskilled for any work, for at least the next two years because of the impairment; or be permanently blind.[141]

10.118 Under the new legislation, people will not be eligible for DSP if they can work 15 hours or more a week at award wages without ongoing support within the two years from assessment.[142] These people will instead be eligible for Newstart or

---

139 *Submission 476,* p. 40.

140 Senate Community Affairs Legislation Committee, *Provisions of: Employment and Workplace Relations Legislation Amendment (Welfare to Work and Other Measures) Bill 2005, Family and Community Services Legislation Amendment (Welfare to Work) Bill 2005*, November 2005, [hereafter *'Welfare to Work'*].

141 Australian Government, *Submission 476,* Attachment 11, p. 1.

142 *Submission 476,* Attachment 11, p. 1; Senate Community Affairs Legislation Committee, *Welfare to Work*, November 2005, p. 19.

Youth Allowance. Newstart and Youth Allowance have lower payment rates than DSP and the implications of private income on these payments differ to DSP.[143]

10.119 Newstart and Youth Allowance, unlike DSP, are also subject to part-time participation requirements. This means that people assessed as able to work at least 15 hours per week unsupported are required to:

- undertake 30 hours per fortnight of paid work; or
- job search for part-time work, participate in appropriate employment services, and/or undertake an annual Mutual Obligation activity.[144]

10.120 The Community Affairs Legislation Committee received mixed evidence as to whether the package of legislative changes would achieve the aims of reducing welfare dependency and encouraging workforce participation. Evidence to that inquiry indicated that DSP recipients assessed as suitable for Newstart stood to be worse off financially following the changes.[145] Others indicated that the new arrangements focussed on getting a job, and that those with the capacity to work stood to be better off financially receiving Newstart and engaging 15 hours of paid work, than receiving DSP.[146] ACOSS, St Vincent de Paul and Hanover argued that the overall outcome for people with disabilities would be increased hardship, poverty and/or disadvantage.[147] The Department of Employment and Workplace Relations said that relevant safeguards for people with disabilities had been incorporated into the legislation, including for people with episodic mental illnesses.[148]

10.121 The government majority on the Community Affairs Legislation Committee concluded there was 'nothing in this legislation which ineluctably will force or coerce any person who is not able to work off income support benefit'.[149] Other committee members dissented from the report with the ALP, Australian Greens and Australian Democrats recommending the bills be opposed on the basis that the 'necessary amendments amount to a complete redraft of the bill'.[150]

---

143   Refer to www.centrelink.gov.au/internet/internet.nsf/payments/disability_support.htm; www.centrelink.gov.au/internet/internet.nsf/payments/newstart.htm; www.centrelink.gov.au/internet/internet.nsf/payments/youth_allow.htm, (accessed March 2006).

144   Senate Community Affairs Legislation Committee, Report, *Welfare to Work*, November 2005, p. 20.

145   Report, *Welfare to Work*, November 2005, p. 69.

146   Report, *Welfare to Work*, November 2005, p. 32.

147   Report, *Welfare to Work*, November 2005, pp. 6, 29-30.

148   Report, *Welfare to Work*, November 2005, pp. 41–42.

149   Report, *Welfare to Work*, November 2005, p. 58.

150   Report, *Welfare to Work*, p. November 2005, 93.

Role of Centrelink

10.122 Centrelink determines eligibility for income support payments and is the gatekeeper for the Job Network, although people on DSP are now able to register directly with Job Network. Centrelink, along with Job Network providers, also identifies people eligible for participation in the Personal Support Program.[151]

10.123 The Australian Government submitted that measures are in place to 'ensure that Centrelink and its staff respond appropriately to people with mental health problems or mental illness'.[152] These include that Centrelink:

- works in partnership with many community and mental health services in relation to suicide prevention strategies;
- liaises locally with mental health services to coordinate service provision;
- conducts training for internal staff and external services in relation to identifying and assisting people with mental health problems or mental illness to access government income support benefits; and
- has developed service guidelines to ensure appropriate income support services are provided to people with mental health problems or mental illness.[153]

10.124 The Australian Government stated that Centrelink has a range of specially trained staff, including Centrelink Disability Officers (CDOs) who assist customers and provide training to other staff, 500 social workers who conduct assessments, provide telephone based counselling and provide referrals to other services, and 250 psychologists who target early identification in relation to mental health illness for people on income support payments.[154]

Comprehensive work capacity assessments

10.125 Under the 'welfare to work' provisions a new assessment process – comprehensive work capacity assessment (CWCAs) –apply for people with disabilities seeking income support. These will involve face-to-face interviews with a range of allied health professionals, such as counsellors, occupational therapists and psychologists.[155] The Australian Government submitted that:

> The assessment will be a positive, holistic exploration of a job seeker's participation barriers, work capacity and the nature of interventions and assistance needed to improve current and future work capacity. At the completion of the assessment, assessors will discuss appropriate

---

151 Australian Government, www.workplace.gov.au/workplace/Category/SchemesInitiatives/PSP (accessed March 2006).

152 Australian Government, *Submission 476,* Attachment 12, p. 1.

153 Australian Government, *Submission 476,* Attachment 12, p. 1.

154 *Submission 476,* Attachment 12, p. 2.

155 *Submission 476,* Attachment 12, p. 3.

participation assistance options available to the job seeker and will arrange rapid referral of the job seeker to an appropriate provider.[156]

10.126 Assessors will have access to a new Prevocational Assistance Account, to organise short-term assistance aimed at improving work capacity, such as 'pain management courses, work conditioning courses (such as fitness for work) or mental health interventions'.[157]

10.127 It is not entirely clear how these one-off assessments will facilitate a comprehensive assessment of the work capacity of people who experience mental illnesses, particularly those who with disorders that are episodic in nature. Professor Ian Webster submitted that 'medical specialists unfamiliar with real-life situations of people in their communities make hard indeed punitive decisions about a person's capacity'.[158] He argued that professionals engaged in the ongoing follow up of particular patients are those best placed to make judgements about the severity of a person's disability.

10.128 The Australian Government noted that a pilot program is currently being conducted which will inform the set up of the CWCA measure. The pilot will examine the extent and nature of short-term interventions, current service gaps and whether direct purchase of recommended short-term interventions by employment service providers is feasible. It is suggested that the pilot will be of particular relevance to those with a mental illness, as 'the pilot will identify job seekers who, for example, may need access to a short period of cognitive behaviour therapy or counselling to address anxiety and depression prior to commencing focused employment assistance activity, and the success of otherwise in obtaining these services'.[159]

Income support issues

10.129 The committee heard about three main areas of concern: the adequacy of income support, the onerousness of compliance requirements, and problems dealing with Centrelink.

Adequacy of income support

10.130 Submissions raised concern about the adequacy of income support generally:

> the fact that social security payments are generally pegged and paid below the Henderson Poverty Line, is a significant contributor to people either living in or being at risk of poverty, homelessness and poor mental health across Australia.[160]

---

156   *Submission 476,* Attachment 12, p. 3.

157   *Submission 476,* Attachment 13, p. 1.

158   Professor Ian Webster, *Submission 458*, p. 31.

159   Australian Government, *Submission 476,* Attachment 12, p. 2.

160   Homeless Persons' Legal Clinic, *Submission 41*, p.32. See also ACOSS, *Submission 457*, p.5.

10.131   The link between inadequate income support and poverty was reported as particularly problematic:

> In addition to being excluded from the earning of adequate income, people with disabilities often have higher costs of living associated with their disabilities. This can be the high and continual cost of medication, equipment or aids, appropriate housing, transport, and services related to personal care or maintenance of a person's home.
> The combination of higher costs of living, along with income deprivation, leads to a strong connection between disability, illness and poverty.[161]

10.132   Anglicare Tasmania observed that the 'poverty experienced by so many people with mental illness doesn't simply restrict their capacity to choose services or activities which are health promoting; it can actively aggravate illness and be a direct cause of hospitalization'.[162] Anglicare described the destitute circumstances of many people with severe mental illness in areas of basic need, such as food, clothing and accommodation.[163]

10.133   The Brotherhood of St Laurence reported consumers' experiences of living on income support long term. One consumer said:

> There is just not enough money to live on, so what you do is rob Peter to pay Paul. Your electricity is going to be cut off so you go into a cycle of debt—you borrow from friends and family and then you borrow from someone else to pay it back. It ends up borrowing and borrowing and borrowing, and you are a burden on the people you know and they start avoiding you because you always need something…you start feeling like a leech. And then you don't want to be seen in the supermarket buying food because you still owe someone money. You wear out your family, you wear out your friends, and you start avoiding people and they start avoiding you. It adds to your exclusion and the other awful thing that follows quickly is that it is very hard to fight the bitterness and the resentment that you start to feel about everything.[164]

Compliance requirements – breaches and penalties

10.134   Breach penalties apply to those who fail to comply with requirements linked to their payments. There are two types of breaches – activity test and administrative. Activity test breaches can be failing to accept a reasonable offer of employment or failing to attend a job interview. An administrative breach can be failure to attend an interview with Centrelink.[165]

---

161   ACOSS, *Submission 457*, p.6.

162   Anglicare Tasmania, *Submission 464,* p. 4.

163   *Submission 464,* pp 20-26.

164   Brother of St Laurence, *Submission 97,* p. 6.

165   Senate Community Affairs References Committee, *Report on poverty and financial hardship,* March 2004, p. 34.

10.135 Breach penalties, such as loss of income for even a short period, can have a significant impact on the welfare of people with a mental illness reliant on income support. Anglicare Tasmania commented:

> The new reforms are being heralded as introducing a better compliance framework, based on a new suspension model. However, this system also contains financial penalties for non-compliance (no back pay of suspended income if the allowee's excuse for non-compliance is not deemed reasonable, and 100 per cent loss of income on fourth suspension)… Concerns about the fate of vulnerable jobseekers and children in households with suspended incomes have been responded to with the promise of more intensive case management of vulnerable jobseekers which will ensure that essential bills are paid when suspension penalties are in place. However, with no funding apparently attached to this initiative it is not clear whether this means referral to the Emergency Relief network or a direct crisis voucher system administered by Centrelink. Nor is there any clarity about what constitutes an essential bill. Either way it appears to introduce more complexity into an already punitive and difficult system.[166]

10.136 Complying with activity and administrative requirements, such as keeping appointments, can be exceedingly challenging for consumers during a period of illness. Other compliance requirements, such as proof of identity, are also challenging for people with mental illness in particularly vulnerable situations, such as homelessness. It was suggested that proof of identity requirements be changed so that homeless people can use a letter from a homelessness assistance provider.[167]

Experiences dealing with Centrelink

10.137 Evidence from consumers and carers was at odds with the government's description of Centrelink's services and approach:

> I believe that the accountability and proficiency of agencies such as Centrelink needs to be urgently reviewed. Their treatment of persons with a psychiatric illness and carers is – in my opinion and experience – absolutely appalling. …I believe that Centrelink staff dealing with the mentally ill should have comprehensive training, that outdated claim forms should be replaced, and that it should be compulsory for Centrelink staff to liaise with health professionals when considering claims from and reviews of disability pensions, carer pensions and carer allowances.[168]
>
> …..
>
> As I can only work approximately 10-12 hours per week, and am on a part-pension I have had many dealing with Centrelink. There were times when I was so frustrated with Centrelink that I ended up feeling completely helpless and extremely distressed. Having to fill out the often complicated forms is also a very difficult task for someone with an illness. Turning up for appointments at Centrelink or at a prospective employers is sometimes impossible for someone with anxiety, depression or any other mental

---

166   Anglicare Tasmania, *Submission 464*, p. 13.

167   Homeless Persons' Legal Clinic, *Submission 41*, p. 34.

168   Name withheld, *Submission 124*, p. 5.

> illness. However Centrelink threatens to cut our payments if appointments are not met.[169]
>
> …..
>
> During this time, she failed to attend an interview, which would have provided her with a disability pension. Owing to her illness, she would often perceive her family members as enemies, so that visiting her was like walking an emotional tight rope. On a rare visit, if I had not accidentally come across the letter informing her that she would <u>not</u> receive the pension because she had failed to attend the appointment, I am certain that she would have continued on her downward spiral. It seemed ironic that the severity of her disability had almost jeopardised her chances of receiving assistance. No attempt had been made to follow up her lack of attendance. This seems to indicate yet another lapse in the support network.[170]

10.138   These experiences was also reported by a health professional:

> I visited a patient who was under my care in Liverpool Hospital; he was a long standing patient. He was very poor and had major health problems and depended totally on income support for bare survival. He was extremely disabled.
>
> When I arrived at the bedside he was weeping. He showed me a letter he just received from CentreLink which had cancelled his Disability Support Pension. I can't recall the exact reason but it was a trivial requirement of failing to respond to a request of some kind. I tried there and then to contact the Department to find out what was going on. From my point of view, indeed of anyone who could see, he was a person with severe disability which was unchanged, indeed deteriorating.
>
> That was frustrating. All I achieved was going into a "pushbutton" queue in ever increasing circles. Later in the day I decided to visit the CentreLink office in Liverpool to speak directly to a responsible officer. That did not work either. There was an apologetic somewhat embarrassed officer who did not know what to do: the most that could be offered was a form to fill in…
>
> There is a preoccupation around testable medical states, a search for <u>objectivity</u> and a philosophy which seems to accept that the prime task is to protect the social welfare system against fraud and malingering.[171]

10.139   The committee notes that some of these issues may be picked up in the early intervention and engagement pilot currently being run by Centrelink,[172] although it is not a project specifically targeted at avoiding the access and compliance problems reported in incidents such as those described above.

---

169   Name withheld, *Submission 237*, p. 2.

170   Name withheld, *Submission 62*, p. 3.

171   Professor Ian Webster, *Submission 458*, pp. 30, 32–33.

172   Australian Government, *Submission 476, Attachment 12*, p. 2.

Community involvement

10.140 The committee received evidence of the importance of community participation and social involvement for people with mental illnesses. The St Vincent de Paul Society commented:

> The system we now have is setting people up to fail. Social isolation and loneliness are guaranteed to trigger episodes of mental illness and suicide and the vicious cycle starts all over again.[173]

10.141 NGOs are 'fast becoming the only providers of social and recreational services, effective and relevant advocacy, living skills training and rehabilitation'.[174] The Society argued that social and recreational facilities and friendship programs need to be developed, funded and promoted.

10.142 Professor Gary Bond, Visiting International Speaker for Schizophrenia Awareness Week, argued for services to enhance people's wellbeing and fulfilment. He noted that in the United States, mental health and rehabilitation services are increasingly looking at the personal goals of consumers:

> …many mental health programs have been aimed at stabilisation and ensuring that clients take their medication and not be a nuisance in society. The broader vision of mental health services is to look at what are their personal goals and aspirations. It turns out that most people with psychiatric disabilities have the same goals, wishes and dreams for their lives that all of us have. If you asked a person with a mental illness, 'What would you like for your life?' they would say, 'I want a nice place to live, I want to have a girlfriend, I want to have a job' —a job is very high in their priorities—'and I just want to have a decent life.'
> It turns out that helping people to achieve these basic goals is a win-win situation. These are the goals that family members have for their loved ones and, in terms of society, that we want for our fellow citizens who have a mental illness—that is, they are well-integrated in the community, they are contributing members to the society and they are productive members of society and so on.[175]

10.143 While many dedicated people are working to advance mental health in Australia, evidence to this inquiry shows that due to service gaps and lack of integration, these 'win win' situations are not being systematically achieved.

Concluding remarks

10.144 The National Mental Health Strategy recognises that all areas of government, not just the health sector, have a role in mental health. However, the high levels of poverty and homelessness among people with mentally illness demonstrates that

---

173 St Vincent de Paul Society, *Submission 478,* p. 6.

174 *Submission 478,* p. 12.

175 Professor Gary Bond, Visiting International Speaker for Schizophrenia Awareness Week, *Committee Hansard,* 19 May 2005, p. 74.

cross-sectoral support is inadequate. There are significant service gaps, and lack of integration and coordination between existing services is a major problem.

10.145 If 'mainstream' welfare services are to be relied upon to provide the range of supports necessary for people with mental illness, it is essential that service staff are educated about mental health issues. Programs need to be designed to be responsive to the episodic nature of some illnesses and staff need to be equipped to work effectively with people experiencing illness.

10.146 The provision of suitable accommodation for people with mental illness requires urgent attention. More than a decade after the Burdekin Report brought to light the dire accommodation circumstances of many people with mental illness, many people remain homeless or transient, living in accommodation unconducive to their mental health, or dependent on family members. Crisis accommodation services cannot meet demand and are generally not targeted to meet the needs of people with mental illness. Low cost independent housing is in short supply and supported accommodation remains scarce.

10.147 While governments have recognised that employment plays an important role in prevention and recovery from mental illness, participation rates among people with mental illness in Australia remain low. This is a key area for better education and advocacy, to counter workplace stigma. The committee met inspiring employment providers who are providing long-term support to help achieve stable employment for people with mental illnesses. There is a need for effective information and knowledge sharing in this field, to build on such experiences.

10.148 As discussed in the previous chapter, community-based mental health services are needed to reduce demand for acute services and increase experiences of mental health. It is imperative that these community services are not silos of 'health' services, but provide the broader supports necessary to sustain independent living.