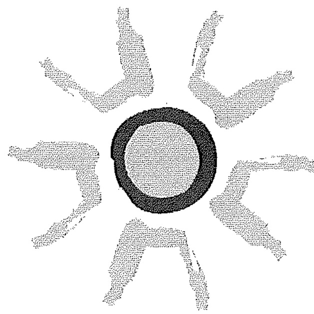

Mental Health Council OF TASMANIA

Submission

A New System for Better Employment and Social Outcomes

Interim Report of the Reference Group on Welfare Reform to the Minister for Social Services

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Introduction

The Mental Health Council of Tasmania (MHCT) is the peak body representing the interests of consumer, carer and community mental health sector organisations, providing a public voice for people affected by mental illness and the organisations in the community sector that work with them. We advocate for effective public policy on mental health for the benefit of the Tasmanian community as a whole and have a strong commitment to participating in processes that contribute to the effective provision of mental health services in Tasmania.

The MHCT applauds the Commonwealth Government's stated intention to put in place a simpler and sustainable income support system which will provide adequate payments based on need that encourage people to prepare for and seek work where it is reasonable to do so. Nonetheless we do have some concerns about possible detrimental outcomes for people with mental illness currently on the Disability Support Pension and for people living with mental health issues in general. The Government points to foreign jurisdictions as examples of similar reforms. The MHCT notes that there are lessons to be learnt from how welfare reforms have been rolled out overseas, particularly in England and New Zealand, and some of these lessons are around what should not be done. We accept that streamlining the system is a good objective, we acknowledge that people with mental illness can fare better with appropriate work and we agree that structural change to support them in the job-seeking and work arena is sorely needed. However, we will not accept any reforms that leave people with mental illness, one of the most disadvantaged groups in society, with further disadvantage.

Underlying principle

At the outset, the MHCT would like it noted that saving money, though not a bad end in itself, cannot be the primary basis for reform. Furthermore, if people with mental illness are placed in stressful and unmanageable situations they are likely to relapse and require yet more psychological or clinical interventions. This is not a solution that can help people or the economy ultimately.

Peter Saunders of the Social Policy and Research Council at the University of NSW has stated that, 'The key objectives of the welfare system are to ensure adequacy of support for those in need, efficiency in order to minimize disincentives to work (and save) and financial sustainability ("The Challenging Triangle" identified in the OECD Making Work Pay

initiative).'[1] The first point Saunders makes is that support must be adequate for those in receipt of welfare and this is exactly how the MHCT views the issue.

The MHCT is pleased that the Interim Report itself states that:

> The system should have adequate payments based on need that encourage people to prepare for and seek work where it is reasonable to do so. It should support people who are unable to work. It should feature fair returns from work, individualised requirements for participating in the workforce, and support services that build individual and family capability. It should be affordable and sustainable now and across future economic cycles. (p. 6)

We trust that the Government will accept this as a basic premise and not go down the path of punitive messages, bullying and a larger number of children living in poverty that reports coming from England and New Zealand describe.[2] The underlying principle of welfare reform must be protecting the most disadvantaged in society and securing a decent standard of living for this group.

Work as a positive experience for people with mental health disorders? Not always.

There is ample anecdotal and empirical evidence that supports the benefits of employment for the wellbeing and recovery of mental health consumers and its role in decreasing the need to use mental health services. But despite the evidence of benefits associated with meaningful activity and contribution, unemployment rates for people with experience of mental illness are considerably high and indeed higher than is the case for the majority of comparable countries. Indeed, people who experience mental illness are amongst those disability groups with the lowest levels of employment.[3] According to the National Mental Health Report 2013, in 2011-12, 62% of working age Australians with a mental illness were employed, compared to 80% of those without a mental illness. Employment participation rates for this group ranged from 52% in Tasmania to 73% in the Australian Capital Territory. Nationally, employment rates for this group decreased slightly from 64% in 2007-08 to 62%

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[1] Peter Saunders, (2010) Child Deprivation in Australia, Findings and Implications for Welfare Reform *Rethinking welfare for the 21st century, Forum Proceedings Report* from the forum held 10 September 2010, at The University of Auckland Business School, p. 20.

[2] Welfare reforms affecting children – CPAG, *New Zealand Herald*, 22 Oct, 2013, http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11144248 This is only one of many articles from both New Zealand and England that describe the more negative effects of the welfare reforms in those countries.

[3] National Mental Health Commission, (2012) *A Contributing Life, the 2012 National Report Card on Mental Health and Suicide Prevention*, Sydney, NMHC.

in 2011-12.[4] The MHCT believes that there are many reasons why this is the case and that these need to be taken into consideration in the review of welfare provisions for people living with mental illness.

However, there remains a tension between the benefits of work for people living with mental illness and the recovery prospects of a person in a vulnerable situation being taken off benefits and, despite being put through training and other job-related activities, still unable to find secure, suitable employment. This latter situation is especially damaging for people with mental illness and is the opposite of the stated purpose of work as a large element in progressing towards good mental health.

Indeed research suggests that not all jobs will have a positive impact for people with on-going mental ill health. Firstly we do not yet have workplace cultures which are informed, aware, flexible and appropriate in their response to employees with mental illness or to maintaining workplace mental health and wellbeing. Furthermore, people with experience of mental illness disproportionately tend to gain employment in low-paid jobs, casual jobs where they are required to turn up when needed which may not always be when they are able. There is a high likelihood of this kind of employment resulting in a disincentive to seek work when unemployed.

The English Marmot Review of Health Inequalities in England reminds us that "Insecure and poor quality employment is also associated with increased risks of poor physical and mental health ... Work is good – and unemployment bad – for physical and mental health, but the quality of work matters. Getting people off benefits and into low paid, insecure and health-damaging work is not a desirable option."[5] Peter Saunders also notes that 'Not all jobs have beneficial effects on well-being: "bad jobs" look more like welfare than "good jobs"'.[6]

Barriers to employment

Aside from the issues of whether employment is in itself always a positive step towards recovery for mental health consumers, there are barriers, both systemic and related to mental illness, to achieving employment which is beneficial to recovery and well-being.

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[4] National Mental Health Report, (2013) Indicator 1a: Participation rates by people with mental illness of working age in employment: general population, Australia, Department of Health, http://health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-report13-toc~mental-pubs-n-report13-3~mental-pubs-n-report13-3-2~mental-pubs-n-report13-3-2-ind1a

[5] Marmot, Michael, (2010) Fair society, healthy lives: the Marmot Review: strategic review of health inequalities in England post-2010, London, University College, p. 26. http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf

[6] Peter Saunders, (2010) Child Deprivation in Australia, Findings and Implications for Welfare Reform *Rethinking welfare for the 21st century, Forum Proceedings Report* from the forum held 10 September 2010, at The University of Auckland Business School, p. 19.

According to the Mental Health Commission the recovery journey is about achieving a contributing life which may not always involve paid work.[7] It is important to recognise the economic value of volunteer service and unpaid work performed by people receiving benefits, including those with mental illness and their carers. At a recent forum on welfare reform held by the MHCT, we heard from consumers about the contributions that they make as advocates, in peer support and general volunteering with little or no pay while still receiving the Disability Support Pension. They are able to do this because the work allows them the flexibility they need to make their contribution. They are fearful that this will not be the case in the future. However, whether contribution does include employment or not, the Mental Health Commission notes that:

> We know that life and circumstances can put barriers in the way of a contributing life. Being able to live a contributing life is not just about having mental health-related recovery goals in place, but can also be about having something meaningful to do and connecting with people.[8]

The barriers that the Commission refers to can be many and varied. We know that mental illness itself is a barrier, particularly with the stigma faced by people with mental illness in the community. Often the symptoms of mental illness, side-effects of medication and the fluctuating nature of mental illness are barriers to participation. We also know that many people with mental illness do not have secure housing, may not live near transport links and have no access to a car. On the whole, as Peter Saunders has noted,

> Welfare recipients often lack the skills needed to be competitive in the labour market.....and often live in areas that lack adequate infrastructure and services. Changes to the benefit system by themselves have limited capacity to overcome the many barriers that prevent those on welfare from accessing a job.[9]

1. Permanency

The Interim report proposes narrowing the eligibility criteria for the Disability Support Pension (DSP). If implemented, this would see the DSP 'reserved only for people with a permanent impairment and no capacity to work.' (p.6)

[7] National Mental Health Commission, (2012) *A Contributing Life, the 2012 National Report Card on Mental Health and Suicide Prevention*, Sydney, NMHC.
[8] National Mental Health Commission, (2013) *A Contributing Life, the 2013 National Report Card on Mental Health and Suicide Prevention*, Sydney, NMHC, p.51.
[9] Peter Saunders, (2010) Child Deprivation in Australia, Findings and Implications for Welfare Reform, *Rethinking welfare for the 21st century, Forum Proceedings Report* from the forum held 10 September 2010, at The University of Auckland Business School, p. 19.

The idea of permanency is a vexed one in the mental sector. There is no agreed definition of permanent. Our colleagues at the Mental Health Council of Australia note their significant concerns about what this concept might mean in practice for people with psychosocial disability. For some types of disability , permanency might be meaningful, for people with psychosocial disability the concept is less clear. If the notion of permanency is not easy to define, this could result in people with mental illness losing benefits, not being able to find employment and existing in a cycle of poverty.

2. Stigma

Stigma and social discrimination towards people living with mental illness is prevalent throughout Australia. The MHCT has been calling for a stigma reduction campaign for many years now. We see this as critical to improving employment prospects for people with mental illness amongst other advantageous outcomes. Rather than reducing stigma, the call for getting people of disability benefits seems to have stimulated a new stigmatisation of people on disability payments in the Australian media.[10] This is in line with what has happened in New Zealand and in England, where there has been an increase in negative media reports about people living with disability, including psychosocial disability since the implementation of welfare reforms.[11]

Prejudicial and unrealistic portrayals in the media mean that those who require social assistance are frequently framed as lazy, immoral and prone to violence. In New Zealand and England media have adopted a negative discourse around the poor, young people, sole parents and people with or recovering from mental illness.

The MHCT would not like to see a similar reaction in Australia. We believe that an anti-stigma campaign would assist the outcomes of the welfare review. In a constricted work environment, stigmatising those on welfare will hardly increase employers' confidence in giving people with mental illness work opportunities. Our recent research project *Stuck in Myself: Isolation and mental health consumers*[12] highlighted the fact that for many people with mental illness, stigma ids one of the main reasons that they feel unable to involve themselves in the community and this includes employment. For a government wishing to help more people with mental health issues into employment or training, this is an issue that must be proactively addressed.

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[10] Beating the bludgers will help the disabled (2014) *The Sunday Telegraph* <http://www.dailytelegraph.com.au/news/opinion/beating-the-bludgers-will-help-the-disabled/story-fni0cwl5-1226969830986?nk=62a6cdfb023b12f02c35ebda637c9047>.

[11] There is so much press on this subject that one need only put "disability scroungers" in Google to access a plethora of such articles.

[12] Mental Health Council of Tasmania, (2014) *Stuck in myself: isolation and mental health consumers*, Hobart, MHCT.

3. Complex needs / wrap around services

The Interim Report notes that: 'For people with complex needs, such as people with severe and persistent mental health conditions, there should be wrap around services that assist them to stabilise their lives and engage in education, work and social activities.' (p. 92)

The MHCT agrees that wrap around services are critical to achieving best outcomes for people with mental illness. The wrap around model of service provision works to help mental health consumers reintegrate into the community, build social supports and follow education and employment pathways. Assisting people with mental illness into positive education or work pathways is not just about training or job centres, it is often about re-building lives. This requires a model that has an inter-sectorial and whole-of-government approach and cannot be achieved without a holistic approach. Wrap around service and programs should include: support services; integrated services; advocacy; rehabilitation; education and training; employment; peer support; community coordination and case management; physical health, clinical health, drug and alcohol services, dentists, care planning (individualised/self-directed care packages); language and cultural organisations; local government; business; housing and homelessness services.

The report refers to the Partners in Recovery (PIR) program as one example of such a service. The MHCT would like to note that this is indeed a good program working well within our state. This is indeed the kind of program that can provide the assistance needed for clients with complex issues. It is critical that such programs are provided across all jurisdictions to secure best outcomes for people living with mental illness, if they are to receive the benefits of integrated services and progress through the recovery journey.

Mutual Obligation

Within the current welfare system, compulsory mutual obligation has not been extended to recipients of the Carer Payment and Disability Support Pension (DSP). Recipients are exempt from mutual obligation job -search activities if they are considered vulnerable, such as people living with mental illness or psychosocial disability. However, recent changes to the eligibility criteria for the DSP saw the introduction of participation requirements to ensure payments continue and recipients remain eligible.

While mutual obligation is encouraged to support people to become more 'self-reliant' and boost employability, the unique experience of mental health consumers and carers must be acknowledged in order to support their health and wellbeing.

The report claims, rightly so, that a more tailored 'individualised approach' would ensure requirements are suited to personal circumstances. Mutual job obligation activities must be appropriate to the individual capabilities and capacity of people with lived experience of mental illness. However, further clarification is required around how the employment service sector will be supported to provide placements and programmes for people living with mental illness.

It is suggested by the Interim Report that the current welfare system would be more effective if sanctions were introduced to improve mutual compliance and this will extend to non-activity tested payments:

> Effectiveness might be improved by giving employment service providers greater management of sanctions, including suspension and penalties ... The system of sanctions should be progressive, with timely, lighter touch measures first and reserving the strongest sanctions for serious non-compliance. (pp. 81-84)

The welfare system was created to support the most disadvantaged members of the Australian community; it is not about punishment and prohibition. Based on evidence of welfare reform overseas, it is clear that enforcing sanctions on some of the most vulnerable people in society, such as those living with mental illness, will be detrimental to health and only exacerbate symptoms.

A flexible and compassionate framework is essential to support the wellbeing of people experiencing mental illness. This will result in a case by case assessment process in consultation with each individual, based on their specific competencies and challenges, whilst acknowledging the unique nature of their illness. It will be crucial to involve and consult with carers in this process, as they experience the multiple levels of hardship alongside their loved ones. Mutual obligation activities must be voluntary and designed to enhance recovery from mental illness and psychosocial disability.

It is important that barriers (also noted above) to compliance are acknowledged:

- People living with mental illness experience a number of symptoms that affect their ability to function and maintain a reasonable quality of life.
- The high level of comorbidity in mental illness means that symptoms are often complex and unpredictable. This unpredictability is caused by the episodic nature of mental illness; people can rapidly become debilitated and unable to participate in activities, such as employment service provider meetings.
- The medication prescribed to people experiencing mental illness can have significant side effects that impact on everyday tasks.
- Stigma and discriminatory behaviours discourage people from participating.

There are many examples with the the United Kingdom and New Zealand welfare reform sytems of the implementation of sanctions and assessment targets that have had a damaging effect on people living with mental illness. The following examples demonstrate a disturbing trend that does not respect or understand the unique nature of mental illness nor does it attempt to acknowledge individual circumstances:

In the UK, a worker at the Department for Work and Pensions described how the sick are treated and what 'harsh targets she is under to push them off benefits'. She claims that letters are sent to the vulnerable who don't legally have to come in, but in such ambiguous wording that they look like an order to attend. Most appalling, if someone fails to comply within the 65-week deadline, they are abandoned.

Another worker in back-to-work training spoke of the angst, fear and panic attacks he witnessed due to welfare sanctions and mutual obligation requirements; including students with severe depression who were threatened with the removal of payments and students with agoraphobia forced to attend noisy classrooms.

Mental health consumers describe the welfare reform in UK and NZ as 'torturous' processes that compounded and worsened conditions. Stories of the cessation of benefits for no reason, false evidence against claimants and a severe lack of compassion are examples of an unjust welfare system that fails to protect basic human rights. This is not what we would like to see for our mental health consumers in Australia

Early intervention

Many mental illnesses develop from late adolescence to the mid-twenties making it difficult to complete schooling. This disrupts further education as well as future work and employment prospects.

The Interim Report notes that, 'While early intervention approaches require up-front investment, this needs to be weighed against the long-term costs of not acting, which include income support dependency, incarceration in justice centres and anti-social behaviour.' (page 85) The MHCT agrees unreservedly that additional investment is critical in programmes and services that are proven to effectively support young people with mental illness to remain engaged with education, employment and training at the earliest opportunity following diagnosis. However we also believe that early intervention is required at every stage of illness. We know that there is a great need for earlier intervention for people of all ages from those who are experiencing mental health difficulties for the first time to those who are experiencing a worsening of their mental health issues or a mental

health crisis in a long line of such episodes. We believe that there are serious consequences of not intervening early and these include economic, accommodation and employment impacts for that person in question.

Conclusion

The "investment approach" is aimed at finding work for those who are likely to stay on benefits the longest and cost taxpayers the most - mainly the sick, disabled and sole parents. It seems to be more focused on reducing benefit payment rather than creating meaningful jobs for people currently receiving welfare supports. The MHCT believes that this should be the other way around. We also believe that looking to other jurisdictions and noting the positive results, in terms of saving money, of welfare reform is not enough. Australia must also look at the impacts on people of such reform.

Simon Chapple, Senior Research Fellow in the Dunedin Multi-disciplinary Health and Development Research Unit, Department of Preventive and Social Medicine, University of Otago, has made an in-depth analysis of the investment model adopted by New Zealand as the basis of their welfare reform. He concludes:

> In the long term, policy makers need to set their sights higher than simply incentivising employment programme performance in terms of earnings outcomes. They need to value, measure and reward operational solutions which directly involve better social outcomes for getting people off benefits and into work – better outcomes not simply for parents, but for their children also, as well as wider society. Again, only if these broader outcomes are explicitly measured and valued will an intertemporal investment approach have any chance to deliver these better outcomes. Only then will ... claims that an investment approach will reduce poverty and improve living standards have operational, as opposed to rhetorical, content.[13]

Finally, as far as the New Zealand model for welfare reform is concerned, Michael Fletcher, Public Policy Lecturer, Auckland University of Technology alerts us to the not as yet defined outcome of reform in New Zealand. While it has achieved a decrease in welfare benefits, it is too early to know if this might not translate into increased spending in other areas including health and the criminal justice system, let alone increases in self-harm, addiction and suicide. In a recent *Lateline* program he said:

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[13] Simon Chapple, (2013) Forward liability and welfare reform in New Zealand, *Policy Quarterly*, Vol. 9, no., 2, p. 62.

At this stage, we don't know very much about the impacts of the welfare reforms in New Zealand. So, I'd be a bit hesitant in your shoes to say, "Well let's just grab it, the whole thing," because at this stage, it's an experiment in New Zealand and we don't really know.[14]

[14] Lateline, http://www.abc.net.au/lateline/content/2014/s4036415.htm Australian Broadcasting Corporation Broadcast: 30/06/2014