NATIONAL MENTAL HEALTH CONSUMER & CARER FORUM

Mental Health Council of Australia

MAKING THE WELFARE SYSTEM WORK FOR MENTAL HEALTH CONSUMERS & CARERS

Submission to the Interim Report by the Reference Group on Welfare Reform

August 2014

Mentally healthy people, mentally healthy communities

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EXECUTIVE SUMMARY

This is a joint submission from the Mental Health Council of Australia (MHCA) and the National Mental Health Consumer and Carer Forum (NMHCCF) in response to the Interim Report by the Reference Group on Welfare Reform.

The MHCA is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector and committed to achieving better mental health for all Australians. MHCA members include national organisations representing consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers and state/territory community mental health peak bodies.

The National Mental Health Consumer and Carer Forum (NMHCCF) is the combined national voice for consumers and carers participating in the development of mental health policy and sector development in Australia.

Overview

The MHCA and the NMHCCF support the view that Australia's welfare system is in need of significant reform. Current payments are typically inadequate to meet basic living costs, and this is acute for some welfare recipients more than others. The current system is complex and confusing. Perverse incentives in the current taxation and transfers system discourage people from entering the workforce when they might benefit from a job, while services to help people participate in employment, education and training are frequently ineffective, difficult to access or non-existent.

Reforms must tackle these major structural challenges if we are to build a system that supports rather than undermines the ability of people receiving welfare payments, including those with mental illness and psychosocial disability, to lead contributing lives.

As the Reference Group has noted, Government must meet its 'mutual obligation' responsibilities by providing effective, coordinated services which build the capacity of individuals in the system to participate socially and economically. Changes to the welfare system need to take place alongside, and complement, changes to these other systems – including some that are the focus of other government-initiated reviews.

A high functioning welfare system which meets the needs of people with mental illness and psychosocial disability would:

- Be easy for people to access and navigate;
- Treat people fairly and in good faith at all times – providing similar benefits to individuals with similar needs;
- Provide welfare recipients with enough money to participate meaningfully in the community, economy and society – as well as meet the basic costs of living and looking for work;
- Focus on individual capabilities through strengths-based assessment and support, rather than focussing on the perceived deficits associated with a diagnosis of mental illness;
- Ensure that people with mental health issues are appropriately identified within the system and referred to the right support services to support recovery;
- Wherever possible, avoid exacerbating known mental health conditions;
- Proactively support mental health consumers and carers to undertake education or training; and
- Provide supported and predictable pathways to social participation and employment for all mental health consumers and carers who are able to work now or wish to work in the future.

- Ensure that services are delivered in culturally appropriate ways

Appendix A outlines the benefits that a high functioning welfare system would deliver for mental health consumers and carers, our economy and government – benefits that extend well beyond the welfare system. It also describes the economic and social risks of not delivering the right reforms.

KEY ISSUES AND RECOMMENDATIONS

Eligibility for DSP

We offer broad support to the report's overarching proposal to simplify the payment structure and allocate supplements to support people who face higher costs of living such as people with disability, people with mental illness and carers.

However, we do not support the proposal that only people assessed as having a 'permanent impairment and no capacity to work' be eligible for the Disability Support Pension. Such an approach would be enormously difficult to implement in practice, as experience to date in the National Disability Insurance Scheme (NDIS) trial sites has shown. More importantly, such a requirement contradicts the well-established recovery paradigm in mental health, which recognises that someone's capacity to work (and indeed to participate more broadly) depends in large part on the support they receive over time – not only on their disability.

RECOMMENDATION 1

Regardless of the structure of payments, the income support system must provide people with disability, including people with mental illness and psychosocial disability, the right support to participate socially and economically, including but not limited to paid work where possible. This entails:

- Exempting people with disability from participation requirements which do not promote their recovery and their capacity to participate, based on assessment of individual circumstances
- Financial supplements to assist individuals in meeting the higher costs of living associated with disability and illness
- Tailored support to build capacity to participate economically and socially, based on plans which reflect individual goals
- Disability, job capacity and employment services assessments carried out in ways that are consistent with current understandings of mental illness
- Incentives designed to reward progress towards individual goals rather than punish non-compliance with arbitrary or unhelpful participation requirements
- Recognition of both vocational and non-vocational participation, including unpaid care, volunteering, education and training, and involvement in community activities.

PAYMENT ADEQUACY

It is well-established that people who rely on income support payments often live in poverty, and as a result are unable to participate fully in their communities for financial reasons. For people with mental illness, as with people with other disabilities, high out-of-pocket costs for care and treatment make the financial barriers to participation particularly pressing.

RECOMMENDATION 2

All income support payments must be adequate to enable individuals and families to meet the costs of living, including the costs of economic and social participation (including job search), with supplements payable to people who incur higher costs of living, such as the costs of treatment and care, as a result of having a disability (including people with psychosocial disability associated with mental illness).

RECOMMENDATION 3

Payment rates for supplements should be determined independently on the basis of 'reasonable and necessary' costs associated with the purpose for which the supplement is intended, including the costs of support and treatment for a disability or illness.

RECOMMENDATION 4

Payment rates should be based on need, not on artificial distinctions drawn from an individual's assessed work capacity.

SUPPORTING CARERS

Carers of people with mental illness do not currently receive the recognition they deserve for their caring role. The value of informal care should be acknowledged through adequate payments, so that carers can continue doing what government would otherwise need to do at much greater expense.

RECOMMENDATION 5

Income support payments for carers must be adequate to enable them to meet the costs of living as well as additional costs associated with their caring role. Supplement payments for carers should be set at a rate which would cover 'reasonable and necessary' additional expenses associated with providing care for people with disability or illness.

RECOMMENDATION 6

Income support for carers should be designed to ensure that mental health carers with significant caring responsibilities are able to access payments to meet the costs associated with providing care for people with mental illness who have episodic needs.

THE NEW ZEALAND INVESTMENT MODEL

While the New Zealand Investment Model has some laudable principles and investment in early investment is beneficial and necessary, we argue that if this model were to be applied in an Australian context, there are several practical issues of implementation that would need to be improved upon for the model to operate effectively for people with experience of mental illness.

MUTUAL OBLIGATION

We know that there is a shortage of available jobs for all people seeking employment, and a frequently a mismatch between the skills of those looking for work and the skills required by employers. This means that people with multiple barriers to employment (including people with mental illness) face additional disadvantage in the current labour market.

We concur with the Reference Group that individually tailored mutual obligation requirements would be preferable to the rigid conditions seen in the present system. Current mutual obligation activities are not easy for people with mental illness to consistently comply with, and can unintentionally lead to an escalation of symptoms or other negative outcomes, further undermining work capacity.

RECOMMENDATION 7

Mutual obligation arrangements must be sufficiently flexible to account for changing circumstances, such an escalation of symptoms of mental illness or impairment related to psychosocial disability. Under these circumstances people must be exempt from mutual obligation requirements. The process of applying for an exemption must be straightforward and people should remain exempt for as long as is determined necessary by a treating professional or designated practitioner.

RECOMMENDATION 8

Mutual obligation requirements should be

- Tailored to individual circumstances and promote recovery
- Proportionate to someone's assessed capacity to participate
- Targeted towards helping people to address barriers to social and economic participation
- Focussed on meaningful activity designed to provide employment skills and/or improve social participation and reduce the impact of disability.

RECOMMENDATION 9

To increase the likelihood of people meeting any mutual obligation commitments without jeopardising their health and wellbeing, welfare recipients should be afforded greater choice and control over the types of mutual obligation activities they are expected to undertake.

We oppose the imposition of punitive sanctions for alleged non-compliance, such as suspensions and non-payment penalties, on people with mental illness. In their place, we propose that positive incentives are put in place to encourage and reward participation. Past evidence has shown that punitive measures make people sicker, potentially leading to hospitalisation – an outcome which is damaging to individuals and expensive for government.

RECOMMENDATION 10

Punitive sanctions for alleged 'non-compliance' should not be applied to people with mental illness or psychosocial disability.

RECOMMENDATION 11

Centrelink should offer positive incentives to reward people for undertaking activities that increase their capacity for economic and social participation. This could include a financial 'participation supplement' or bonus payment.

EMPLOYMENT SERVICES

Mental health consumers and carers need individually tailored employment services and 'wrap-around' support to help them overcome the complex barriers to employment.

Evidence suggests that current models of employment services frequently do not deliver what is needed. This is due to insufficient resources, high client loads (ie a lack of intensive support) and perverse incentive payments that reward short-term job placements and do not resource employment services sufficiently to work with people who need longer-term and often more intensive support to prepare for, find and keep jobs. This situation is not sustainable, and unless it is addressed we will continue to see resources wasted on ineffective services.

Employment placement models, including employer subsidies, with a proven track record should be expanded nationally and that employment services must be permitted the time and space to innovate.

RECOMMENDATION 12

Outcome payments for employment services providers should be based on the achievement of sustainable employment outcomes (for example, at the 26 and 52 weeks' stage), not short term job placements.

RECOMMENDATION 13

Employment services providers should be funded/ resourced to work collaboratively with other services to deliver coordinated support for their clients.

RECOMMENDATION 14

Providers of employment services and other services accessed by people with mental illness, including housing services and community mental health services, should be funded to employ specialist employment consultants with lower client loads to work more intensively with people facing multiple barriers to employment, including people with mental illness and to place those consultants in external agencies where appropriate.

RECOMMENDATION 15

Compliance and reporting requirements should be simplified to free up more time for employment consultants to devote to meeting the needs of job-seekers and employers.

RECOMMENDATION 16

The Australian Government should fund Disability Employment Services to develop and expand best practice models of employment services for people with mental illness and psychosocial disability based on a comprehensive review of what has been shown to achieve the best sustainable employment outcomes for different population groups in Australia and overseas.

RECOMMENDATION 17

Consistent with proposals in the Reference Group's Interim Report, 'wrap around' support packages for people with mental illness and psychosocial disability should be expanded and address both vocational and non-vocational barriers to employment and social participation.

RECOMMENDATION 18

Employment services models such as Individual Placement and Support which have demonstrated superior sustainable job outcomes for people with mental illness should be expanded nationally, and embedded into community mental health services where possible.

Appendix B summarises key themes and findings from our surveys with mental health consumers and carers about their interactions with the welfare system and their experiences with Disability Employment Services. These provide insights into what improvements can be made to the employment services system to support people with mental illness and psychosocial disability.

THE ROLE OF EMPLOYERS

We offer broad support to all initiatives that promote the creation of additional job opportunities for people with disabilities, including psychosocial disability. These include individually targeted initiatives such as wage subsidies, as well as population-level interventions such as awareness-raising about employing people with disabilities. As both a large employer and policy-maker, the Australian Government should lead by example and improve its own employment practices.

RECOMMENDATION 19

The Australian Government should fund an awareness campaign and wage subsidies to encourage employers to hire people with mental illness and psychosocial disability and promote the value of increased workplace diversity**.**

RECOMMENDATION 20

The Australian Government must show leadership in the employment of people with disability by increasing the proportion of people with disability employed in the public service from 3.8% to at least the 1986 level of 6.6% by 2020.

THE ROLE OF INSURANCE

People who take time off work on the basis of a mental illness could be much better supported through insurance. Income protection insurance, and insurance providers, can offer both financial support in lieu of an income, as well as practical support in collaboration with employers for people returning to work. However, many people with experience of mental illness are unable to access these supports, which in many cases could be the result of unfair and potentially discriminatory practices.

RECOMMENDATION 21

The Government should engage with insurance and superannuation providers, as well as relevant regulatory bodies and mental health consumers and carers, on innovative and constructive approaches to income protection insurance to provide better support for people with mental illness to maintain and return to work.

In Appendix C, we explain how stigma against people with mental illness in the broader community remains a significant barrier to economic and social participation.

KEY STATISTICS – MENTAL HEALTH CONSUMERS AND CARERS, INCOME SUPPORT AND WORKFORCE PARTICIPATION

- Approximately 3.2 million Australians experience mental illness at any given time, most commonly anxiety and depression.
- 264,000 people with psychosocial disability currently receive the Disability Support Pension. This equates to 32% of all recipients.
- Over 200,000 recipients of the Newstart Allowance have an identified mental illness.
- 70,000 mental health carers receive Carer Payment. This equates to about 32% of all recipients.
- Australia has a low rate of employment participation by people with mental illness compared with other OECD nations.
- In 2009, 29.2% of people with a psychosocial disability were participating in the labour force and 18.9% were unemployed.
- The labour force participation rate by people with severe and persistent mental illness has only marginally improved over the past 15 years.
- Sustainable employment outcomes by people with mental illness and psychosocial disability following engagement with Job Services Australia and Disability Employment Services are low, ranging from 18% to 30%.

1. ABOUT US

The Mental Health Council of Australia (MHCA) is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector and committed to achieving better mental health for all Australians. It was established in 1997 as the first independent peak body in Australia to truly represent the full spectrum of mental health stakeholders and issues. MHCA members include national organisations representing consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers and state/territory community mental health peak bodies.

The MHCA aims to promote mentally healthy communities, educate Australians on mental health issues, influence mental health reform so that government policies address all contemporary mental health issues, conduct research on mental health issues, and carry out regular consultation to represent the best interests of our members, partners and the community. These endeavours in education and policy reform are matched by our commitment to researching more innovative approaches to the provision of mental health care. In addition, the MHCA continues to focus on the human rights of people with a mental illness.

The National Mental Health Consumer and Carer Forum (NMHCCF) is a united, independent and national voice of consumers and carers committed to reforming mental health in Australia and ensuring services are inclusive of all diverse groups. The NMHCCF aims to improve the wellbeing and quality of life of all mental health consumers and carers throughout Australia through promoting their rights; creating a responsive, recovery focused service system; and through supporting innovation in service delivery appropriate to different life stages.

NMHCCF members represent consumers and carers on a large number of bodies such as government committees and advisory groups, professional bodies and other consultative forums and events. Members use their lived experiences, understandings of the mental health system and communication skills to advocate and promote the issues and concerns of consumers and carers.

Mental health issues affect one in every five Australians. We cannot afford to be complacent in our efforts to achieve changes to our mental health care system when we consider the impact of mental health on our community.

KEY MENTAL HEALTH CONCEPTS USED IN THIS SUBMISSION

Recovery: From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.

More information about recovery and recovery oriented practice in mental health services is available at: http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-i-nongov-toc~mental-pubs-i-nongov-pri

Mental health consumer(s): A mental health consumer is a person who identifies as having a current or past lived experience of mental health issues or mental illness, irrespective of whether that person has a diagnosed mental illness or has received treatment.

2. KEY FEATURES OF A HIGH FUNCTIONING WELFARE SYSTEM

The MHCA and the NMHCCF support the view that Australia's welfare system is in need of significant reform. Current payments are typically inadequate to meet basic living costs, and this is acute for some welfare recipients more than others. The current system is complex and confusing. Perverse incentives in the current taxation and transfers system discourage people from entering the workforce when they might benefit from a job, while services to help people participate in employment, education and training are frequently ineffective, difficult to access or non-existent.

Reforms must tackle these major structural challenges if we are to build a system which supports rather than undermines the ability of people on welfare, including many with mental illness and psychosocial disability, to lead contributing lives.

As the Reference Group has noted, Government must meet its 'mutual obligation' responsibilities by providing effective, coordinated services which build the capacity of individuals in the system to participate socially and economically. Changes to the welfare system need to take place alongside, and complement, changes to these other systems – including some that are the focus of other government-initiated reviews.

The ultimate goal must be the development of a high functioning welfare system.

A high functioning welfare system which meets the needs of people with mental illness and psychosocial disability would:

- Be easy for people to access and navigate;
- Treat people fairly and in good faith at all times – providing similar benefits to individuals with similar needs;
- Provide welfare recipients with enough money to participate meaningfully in the community, economy and society – as well as meet the basic costs of living and looking for work;
- Focus on individual capabilities through strengths-based assessment and support, rather than focussing on the perceived deficits associated with a diagnosis of mental illness;
- Ensure that people with mental health issues are appropriately identified within the system and referred to the right support services to support recovery;
- Wherever possible, avoid exacerbating known mental health conditions;
- Proactively support mental health consumers and carers to undertake education or training; and
- Provide supported and predictable pathways to social participation and employment for all mental health consumers and carers who are able to work now or wish to work in the future.
- Ensure that services are delivered in culturally appropriate ways

A welfare system with these features would deliver great benefits for individuals, the community, the economy and government.

Equally, there are substantial risks if we do not deliver the right reforms or if reforms result in the removal of vital support from people too quickly without the provision of access to adequate alternative support services. These benefits and risks are outlined in Appendix A.

3. MENTAL ILLNESS, BARRIERS TO EMPLOYMENT AND LABOUR MARKET REALITIES

Evidence suggests that while the vast majority of people with mental illness are already in paid employment, employment and labour force participation rates by people with severe and persistent mental illness and psychosocial disability remain low in comparison to the general population (32.5% versus 72.5%)[1] and by international standards[2].

The National Mental Health Commission asserts that this is not because people with mental illness do not want to work; rather, they often face major barriers to participation in paid work[3]. These include:

- Symptoms which fluctuate in severity and impact;
- The impact of these symptoms and the side effects of some psychotropic medications on cognitive functioning, memory and organisational ability;
- The impact of co-occurring disorders;
- Lower educational attainment;
- Lack of work-relevant skills due to time spent out of the workforce;
- High levels of housing instability;
- Multiple levels of disadvantage; and
- Experiences of stigma and discrimination[4].

Despite such barriers, we know that many people with mental illness and psychosocial disability want to work. For example, tens of thousands of people with severe and persistent mental illness and psychosocial disability are actively engaged with employment services and looking for work[5].

We also know that many other people want to support to build their employability by participating in education and training. Meanwhile, rates of volunteering amongst people with mental illness are similar to those of the general population[6] - underscoring their desire to participate more fully in society.

Increasing rates of employment among people with mental illness and psychosocial disability will require effort and innovation on various fronts. New models of employment services are needed along with the expansion of proven models which already exist. Both employers and prospective employees need the right incentives in place. In addition, anti-stigma and mental health promotion campaigns targeted at both employers and community should challenge negative misconceptions and stereotypes, encouraging employers to embrace the contributions that this large – but historically unsupported – population can make in the workplace.

As of December 2013 there were 827,039 people on activity-tested payments with job search requirements, with approximately 140,000 advertised jobs available. Put another way, there were six activity-tested job-seekers for every advertised job in Australia[7]. A significant proportion of these

[1] National Mental Health Commission, A Contributing Life: National Report Card on Mental Health and Suicide Prevention 2012, Australian Government 2013, p.99.
[2] Organisation for Economic Cooperation and Development, Sickness, Disability and Work: Breaking the Barriers, Sickness – Australia, 2010, p.3.
[3] National Mental Health Commission, 2013, op cit. pp.99-101.
[4] These barriers have been identified through multiple sources including surveys commissioned by the MHCA about experiences with the welfare system and support needed to take up work for the purposes of informing this submission.
[5] Disability Employment Services monthly programme usage data presented at DES consumer day, April 2014
[6] National Mental Health Commission, ibid.
[7] Australian Bureau of Statistics, Cat no. 6354.0: Job Vacancies in Australia, May 2014: http://www.abs.gov.au/ausstats/abs@.nsf/mf/6354.0 , Department of Social Services, Youth Allowance (other) and Newstart Allowance recipient data, December 2013.

jobs are likely to be applied for by people who are already in paid employment, including some of the 920,000 people in Australia who are 'underemployed' and would like to work more hours[8].

Put simply, there are significantly more people looking for work already than there are available jobs. In this environment employers can afford to select people with a strong and recent history of paid employment and the current skillsets and/or experience necessary to perform available jobs well. This places people with barriers to employment at a major disadvantage in the labour market – reinforcing the need for people with mental illness to be supported by a high functioning welfare system that is well integrated with person-centered support services.

More than 700,000 people are currently registered with Job Services Australia (JSA) providers and approximately 160,000 people are engaged with Disability Employment Services[9]. If current recipients of the DSP and Carer Payment are required to participate in these programmes under a new system they will require significant additional funding and resources in order to meet demand. Recommendations for improving the capacity of the employment services system are set out in Section 5.

[8] http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6202.0May%202014?OpenDocument
[9] Department of Employment, Department of Social Services.

4. ELIGIBILITY FOR DSP

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'.

The MHCA and the NMHCCF have significant concerns about what this definition will mean in practice for people with psychosocial disability and how the concepts will be applied. While permanency may be a meaningful concept for some types of disability, for people with disability arising from severe and persistent mental illness it is far less clear. This is because the symptoms of mental illness are often (but not always) episodic and unpredictable, with someone's functional impairments changing markedly over time. Further, for someone with mental illness, 'permanency' may be assessed very differently depending on when and how the assessment is made and who makes it.

Experience from the National Disability Insurance Scheme trial sites has brought into focus how problematic the concept of 'permanency' can be in relation to mental illness.

Legislation stipulates that to meet the disability access requirement for the NDIS, a person's disability must be 'permanent or likely to be permanent'[10]. The MHCA has heard many stories about the practical challenges for the NDIA in determining whether a disability is permanent on an individual basis. There are no standard tools for assessment of permanency, and the concept is at odds with the widely accepted goal of recovery from mental illness.

If reforms to the welfare system rely on the concept of permanency, there is a major risk that the Government will encounter these very same challenges, with no obvious solutions. These include a lack of clarity about who is eligible and who is not, leading to people with seemingly similar levels of impairment being treated differently, and confusion about where the threshold lies between 'permanent' and 'temporary'. In the context of the DSP, relying on this concept could lead to an increase in the number of cases lodged with the Social Security Appeals Tribunal by people not granted DSP on the basis that their condition is not permanent. It is difficult to see how the tribunal might arrive at a definitive ruling in these cases.

Highlighting the practical problems with the concept of permanency, it is worth noting that there are currently multiple definitions of the terms 'permanent', 'likely to be permanent' and 'on-going disability' in use in a range of contexts within Australia (see Table 1 below). These include:

- DSP - providing evidence (from an approved practitioner) to demonstrate that the condition or disability is expected to last for **two years or more**.
- NDIS – To access individualised funding packages (tier 3), NDIA assessors must be satisfied that your condition is **permanent, or likely to be permanent**; it does not specify a minimum period of time.
- Carer Payment – Carers must supply evidence (a questionnaire completed by themselves and an approved practitioner) that demonstrates the supports that a person needs and that there condition/disability can be expected to last for **at least 6 months** (long term support).
- Determining compensation for total and permanent disability/legal definition – To satisfy the legal definition of total and permanent disability the acquired condition or disability must be sufficient to prevent the person from working in their own occupation or any for which they are suited by training, education, or experience **ever again (permanent means for the rest of the person's life).**

[10] National Disability Insurance Scheme Act 2013, p.1, s.24 http://www.comlaw.gov.au/Details/C2013A00020

Table 1: Existing definitions of permanent, on-going disability and impairment

Purpose/source	Definition of Permanent	Impairment/impact on capacity
DSP (eligibility for payment)	A disability/impairment that is expected to last **more than 2 years.**	Condition/disability must be fully 'diagnosed treated and stabilised' and satisfies criteria in relevant impairment tables (as evidenced by an approved medical practitioner). Work capacity of <15 hours per week.
National Disability Insurance Scheme (disability access requirement)	Condition must be permanent or likely to be permanent; Unclear though the scheme is intended to provide **lifelong support.**	Your impairment substantially reduces your ability to take part effectively in activities or perform tasks or actions; You have assistance from other people on most days.
Adult Disability Assessment Tool (eligibility for Carer Payment)	A disability that requires and is expected to require significant on-going care on most days for **at least 6 months (unless the condition is terminal).**	The primary care-giver is required to complete questionnaire outlining the types of activities/functions that a person has difficulty performing. Part two is to be completed by a 'treating professional'.
Diagnostical and Statistical Manual (DSM V)	Symptoms and/or associated impairment expected to last **2 years or more.**	Used to determine the likelihood that a mental illness will become 'long-term'
Motor Accident Commission (determination of claim & amount)	Unable to work in their own occupation or any for which they are suited by training, education, or experience **ever again**	Total and Permanent Disablement Insurance is designed to provide a lump sum benefit to the life insured in the event of a medically diagnosed event that renders the claimant unable to work again.
Australian Legal Dictionary	An injury that impairs the physical or mental ability of a person to perform his or her normal work or non-occupational activities supposedly for **the remainder of his or her life.**	Used to calculate level of impairment to the 'whole person' on the basis of loss of limbs or brain function.
Proposed definition for DSP eligibility in the Interim Report	Unclear	Unknown.

Table 1 also illustrates that in addition to multiple definitions of permanency there is also significant variation in terms of the level impairment that a person must have, depending on the purpose of the assessment.

In addition, restricting the DSP to people with 'no capacity to work' creates another problem. It carries the risk of creating, or further entrenching, a class of income support recipients that Departmental assessors have the authority to 'write off' from ever being able to undertake paid work or improve their capacity on the basis of a point in time assessment.

This is completely at odds with the purpose of introducing new impairment tables in 2012 which focused on what people 'could do' in terms of education, employment and training, rather than what they could not[11]. It is also inconsistent with recent statements from the Government about what it is hoping to achieve by reforming the welfare system. The Minister for Social Services, the Hon. Kevin Andrews has previously stated that:

> *"…We don't want to condemn people to what is virtually a dead-end these days in terms of the DSP…"*[12]

The Reference Group's Interim Report rightly referred to the findings of the Henry Review, which concluded that 'predicting the employment prospects of people with disabilities is inherently difficult'[13] – an observation which arguably applies in greatest measure to people with mental illness. The Henry Review also observes that the severity of someone's disability, and their capacity to work in the long term, may depend substantially on the support they receive – including support to become work-ready, but also other services critical to wellbeing that are delivered beyond the welfare and employment services systems.

The Interim Report acknowledges that many people with mental illness and psychosocial disability will require significant assistance in order to successfully transition into the workforce. In addition to these people, there are of course others for whom paid work is not realistic for the foreseeable future. Both these groups have overlapping needs and must receive adequate financial and other support to enable them to live contributing lives. This could be achieved by removing the current divide between people who meet eligibility requirements for the higher DSP payment and those who fall just short and end up on the lower Newstart (incapacitated) payment, and providing both groups with the same level of payment that would meet basic living costs, the costs of participation, and additional costs associated with having a disability or illness.

Bearing these considerations in mind, the MHCA and the NMHCCF believe that there is little merit to the Reference Group's proposal that DSP be reserved 'only for people with a permanent impairment and no capacity to work'. Doing so would perpetuate the current (and highly inequitable) scenario, in which some people with disabilities receive a higher payment but little support to enter the workforce, while others (who are assessed as having a lower level of disability at a particular point in time) receive a lower payment and must meet stringent work participation conditions. The criteria proposed to distinguish between these two groups – and potentially determine what support someone gets for decades to come – are based on concepts that are demonstrably difficult to implement in practice.

[11] http://www.dss.gov.au/our-responsibilities/disability-and-carers/benefits-payments/disability-support-pension-dsp-better-and-fairer-assessments/review-of-the-tables-for-the-assessment-of-work-related-impairment-for-disability-support-pension/social-security-tables-for-the

[12] Australian Broadcasting Corporation, "Kevin Andrews Defends Plan to alter Disability Support Pension Entitlements", 23/12/2013.

[13] Department of Social Services, A New System for Better Employment and Social Outcomes: Interim Report of the Reference Group on Welfare Reform to the Minister for Social Services, Australian Government, Canberra, 2014, p.47.

RECOMMENDATION 1

Regardless of the structure of payments, the income support system must provide people with disability, including people with mental illness and psychosocial disability, the right support to participate socially and economically, including but not limited to paid work where possible. This entails:

- Exempting people with disability from participation requirements which do not promote their recovery and their capacity to participate, based on assessment of individual circumstances
- Financial supplements to assist individuals in meeting the higher costs of living associated with disability and illness
- Tailored support to build capacity to participate economically and socially, based on plans which reflect individual goals
- Disability, job capacity and employment services assessments carried out in ways that are consistent with current understandings of mental illness
- Incentives designed to reward progress towards individual goals rather than punish non-compliance with arbitrary or unhelpful participation requirement; and
- Recognition of both vocational and non-vocational participation, including unpaid care, volunteering, education and training, and involvement in community activities.

In advocating this option, the MHCA and the NMHCCF stress that it is critical that people with psychosocial disability who face higher costs of living associated with support and treatment for mental illness are not left financially worse off.

The advantages of such an approach would include:

- Consistent treatment of people with comparable levels of material need (related to disability and illness);
- Potential simplification of the payment structure (reducing complexity and administration costs);
- Encouragement of a strengths-based philosophy that focuses on delivering effective interventions that support people to participate to the fullest extent possible (rather than a deficits model that sees people 'pensioned–off' and left unsupported by Centrelink); and
- Participation requirements that could be more easily adjusted having regard to changing circumstances and capacity (including episodic fluctuations in the severity of symptoms or impairment resulting from mental illness).

5. PAYMENT ADEQUACY

While acknowledging that simplifying the income support payment structure would deliver many benefits (e.g. reduced complexity, administration costs and red tape), the MHCA and the NMHCCF are concerned that mental health consumers and carers may be disproportionately affected by the proposed new payment structure outlined in the Interim Report.

As noted above, the proposal to restrict the DSP only to people whose disabilities can be defined as 'permanent and profound' and who have 'no capacity to work' could, depending on how it is implemented in practice, affect the majority of people currently receiving the DSP for psychosocial disability associated with mental illness.

The Reference Group's report does not provide any indication of the number of people currently receiving the DSP who have no capacity to work now or in the future; indeed, it is unclear whether this information is currently held by the Department of Human Services, so it is therefore unclear how many would continue receiving DSP.

'People with psychiatric/psychological impairments' are specifically mentioned on several occasions in the report as a group of people current receiving the DSP in large numbers who 'with appropriate interventions' and 'flexible participation requirements' could be 'supported in ways to enable them to gain and maintain employment'.

This suggests that a significant number of the 264,000 people currently receiving the DSP for psychosocial disability[14] could be transferred to the proposed new Working Age Payment.

Without knowing the rate for the proposed Working Age Payment or the supplement that recipients might receive if they have a disability, it is not possible to determine whether or not people transferred from the DSP would be worse off financially and, if so, how much worse off. We would of course be extremely concerned if reforms to the welfare system (intentionally or otherwise) resulted in people receiving lower payments because they have a particular type of disability, rather than because their needs are different. We also caution that Australia's commitment to the UN Convention to the Rights of Persons with Disabilities carries with it an obligation to treat people equally regardless of their disability type.

Mental health consumers have told the MHCA that they find it incredibly difficult to meet 'basic costs of living' on the DSP. If a significant number of people were moved to a Working Age Payment and the payment is lower than the current rate for the DSP, they would be even less able to meet the costs of living, which for those with new participation requirements may be even higher than they are at present.

The report states that a 'properly functioning income support system would provide adequate payments based on need encouraging people to use their own resources to support themselves and look for work where it is reasonable to do so'[15].

The Reference Group should give due consideration to the establishment of a mechanism to determine, and provide independent and transparent advice to government on, what constitutes adequate payments to meet the costs of living including the costs of economic and social participation. In the case of people with disability, income support payments must also be sufficient to enable people to meet the costs of reasonable and necessary support and treatment that they may require in order to stay well and/or continue on the path to recovery.

The development of this benchmark should be informed by a public inquiry into minimum socially acceptable living costs conducted by an independent Commission of experts appointed by

[14] Department of Human Services, Characteristics of Disability Support Pension Recipients, Australian Government, 2014.
[15] Department of Social Services, A New System for Better Employment and Social Outcomes: Interim Report on Welfare Reform to the Minister for Social Services, Australian Government 2014, p.41.

Government for that purpose.

RECOMMENDATION 2

All income support payments must be adequate to enable individuals and families to meet the costs of living, including the costs of economic and social participation (including job search), with supplements payable to people who incur higher costs of living, such as the costs of treatment and care, as a result of having a disability (including people with psychosocial disability associated with mental illness).

RECOMMENDATION 3

Payment rates for supplements should be determined independently on the basis of 'reasonable and necessary' costs associated with the purpose for which the supplement is intended, including the costs of support and treatment for a disability or illness.

RECOMMENDATION 4

Payment rates should be based on need, not on artificial distinctions drawn from and individual's assessed work capacity.

6. SUPPORTING CARERS

The MHCA and the NMHCCF note with some concern the report's proposal that the Carer Payment could be abolished, with current recipients transferred to a Working Age Payment which would be topped up with a supplement paid to people with 'limitations on work availability because of caring'[16].

In order to receive Carer Payment, currently someone must demonstrate that they are providing 'constant care', which is generally if care is provided on a daily basis for a 'significant period' during each day. The estimated 70,000 mental health carers already in receipt of Carer Payment[17] would of course have a limited capacity to undertake paid employment even if suitable jobs were available.

Many more carers have told us that they struggle with near full time caring responsibilities but find themselves ineligible for Carer Payment. The inability of the current system to accommodate caring responsibilities which fluctuate over time is a major failing of the current system.

A number of carers who have shared their personal experiences with the MHCA have stressed that the role of caring is in fact work and should be regarded as such. Some have expressed the view that the Interim Report diminishes and devalues their social role. They point out that while the intensity of their caring responsibilities (in terms of the number of hours spent in a direct caring role each day) may vary, it is often a 24 hour responsibility and does not allow for predictability.

As such, many are unable to tell an employer what hours they could work each week or each fortnight in advance as this may change depending on what happens in the life or lives of the person(s) that they care for.

Other carers have told us that they want to combine paid work with their caring work but would need tailored support to do so and an understanding employer. They have told us that when they have previously undertaken paid work it has often been unsustainable because of the level of flexibility they need in terms of rostering, hours of employment and leave requirements that may be needed at very short notice. For these people, employers were unable to accommodate this degree of flexibility.

In short, most carers that we have heard from want to work where possible, but they also want to be duly acknowledged for the significant care work they are already undertaking to support people with mental illness and psychosocial disability.

For carers whose responsibilities are full time who are unable to undertake paid work, there must be adequate financial support and access to appropriate and timely respite options. Without this, many carers are at risk of becoming seriously ill themselves as a result of not having sufficient supports in place to help them manage their caring role.

Many recipients of Carer Payment have been out of the paid workforce for a number of years. In addition to the need for jobs with sufficient flexibility to accommodate caring responsibilities, they will also require pre-employment support, training or up-skilling in order to become work-ready.

Due consideration must be given to whether or not current models of employment services, typically characterized by high caseloads and a lack of resources to provide the tailored intensive assistance for people who have been out of the paid labour force for some time including carers who wish to return to work. The value of informal care should be acknowledged through adequate payments, so that carers can continue doing what government would otherwise need to do at greater expense. Carers of people with episodic mental illness must also be able to access income support payments when they need them.

[16] Department of Social Services, A New System for Better Employment and Social Outcomes: Interim Report on Welfare Reform to the Minister for Social Services, Australian Government 2014, pp. 50-51
[17] Department of Social Services, 2014.

RECOMMENDATION 5

Income support payments for carers must be adequate to enable them to meet the costs of living as well as additional costs associated with their caring role. Supplement payments for carers should be set at a rate which would cover 'reasonable and necessary' additional expenses associated with providing care for people with disability or illness.

RECOMMENDATION 6

Income support for carers should be designed to ensure that mental health carers with significant caring responsibilities are able to access payments to meet the costs associated with providing care for people with mental illness who have episodic needs.

7. THE NEW ZEALAND INVESTMENT MODEL

The forward liability model operating in the New Zealand welfare system has some laudable principles, particularly its focus on early investment. This focus aligns well with the long-held position of the mental health sector around the health, social and economic benefits of prevention and early intervention in mental illnesses.

However, the NZ approach has a number of limitations. If this model were to be applied in an Australian context, there are several practical issues of implementation that would need to be improved upon for the model to operate effectively for people with experience of mental illness. Namely, it should:

- Encompass interventions that are both early in a person's life (ie. Targeting young people) and early in a person's experience of a potentially destabilising situation or other risk factors (i.e. that may occur at any stage over the life course, such as the onset of mental illness);
- Recognise that the most effective early intervention supports may not be directly related to vocational or employment-related barriers. For example, securing stable housing may be the most cost-effective avenue to assist a person to become 'job-ready';
- Take a more sophisticated and comprehensive approach to the identification and measurement of outcomes that are necessarily specific to employment and earnings. For example, a consistent set of whole-of-life mental health targets and indicators could improve the accuracy and utility of a forward liability approach, whilst also providing a consistent basis for designing, implementing, and monitoring a variety of policy and service delivery initiatives across government.

These improvements would better recognise the full range of factors including clinical issues but also extending to factors such as stable housing and social participation that can be both the causes of and solutions to barriers to employment, for people with lived experience of mental illness.

Recognising and incentivising action to address these factors requires whole-of-government efforts, including engaging with consumers, service providers and funders across government portfolios and at state and federal levels. While this action may be beyond the scope of the current review, it is critical to acknowledge in this process that a whole-of-government approach – or, more accurately, the lack thereof – is a key structural driver of inefficacy and ineffectiveness in a variety of areas of public policy and service delivery with significant implications for the welfare system.

8. MUTUAL OBLIGATION

We know that there is a shortage of available jobs for all people seeking employment, and a frequently a mismatch between the skills of those looking for work and the skills required by employers. This means that people with multiple barriers to employment (including people with mental illness) face additional disadvantage in the current labour market.

To date, compulsory mutual obligation has not been extended to recipients of the Carer Payment or Disability Support Pension. In addition, over 300,000 recipients of the Newstart Allowance are exempt from 'mutual obligation' (job-search) activities, many of whom have vulnerability indicators attached to their files due to factors such as mental illness and/or homelessness[18].

However, recent changes mean that many people receiving the DSP are required to demonstrate that they have 'actively participated in a programme of support'[19] in order to continue to remain eligible for the payment. While it is compulsory to attend an interview to discuss the programme of support, participation in activities is voluntary. The recent budget measure will make participating in agreed activities compulsory for DSP recipients aged under 35 who are subject to review[20]. The Interim Report also proposes extending mutual obligation requirements to significant numbers of people who are currently on 'non-activity tested payments'.

Determining the kinds of mutual obligation activities that are appropriate for recipients of these payments should not occur without meaningful consultations with mental health consumers and carers to ensure that any measures that are imposed benefit people and do not make mental health conditions worse.

The MHCA and the NMHCCF concur with the report's assertion that, in their current form, compulsory mutual obligation activities do not meet the needs of significant numbers of people and are unrealistic for others[21]. As the report also notes, it can be difficult for people with mental health conditions to consistently meet mutual obligation requirements, especially when symptoms worsen or a person's impairment becomes more severe. It will be important to ensure that any mutual obligation requirements that may be placed on people with mental illness in the future are sufficiently flexible to account for this common scenario. There must also be appropriate exemptions from mutual obligation requirements should symptoms or impairment resulting from mental illness or psychosocial disability escalate.

RECOMMENDATION 7

Mutual obligation arrangements must be sufficiently flexible to account for changing circumstances, such an escalation of symptoms of mental illness or impairment related to psychosocial disability. Under these circumstances people must be exempt from mutual obligation requirements. The process of applying for an exemption must be straightforward and people should remain exempt for as long as is determined necessary by a treating professional or designated practitioner.

[18] Baker, Andrew, Not Looking for Work: The Rise of Non-Job-seekers on Unemployment Benefits, Centre for Independent Studies, 2013, p.5.
[19] A Programme of support means a programme designed to increase capacity for employment and can include engagement with DES/DMS or JSA.
[20] http://www.humanservices.gov.au/corporate/publications-and-resources/budget/1415/measures/disability-and-carers/52-000738
[21] Department of Social Services, A New System for Better Employment and Social Outcomes: Interim Report on Welfare Reform to the Minister for Social Services, Australian Government 2014, p.81.

Furthermore, mutual obligation requirements must be well targeted and tailored to individual circumstances. Ideally they would be designed to enhance social and economic participation (including providing employment skills) and support recovery from mental illness. In the case of carers, mutual obligation should provide increased opportunities for social interaction, and be supported by increased respite options so as not to place undue additional stress on families and people with mental illness and/or psychosocial disability.

If mutual obligation requirements were to be extended to people with mental illness and psychosocial disability with partial work capacity, they would need to be tailored to individual circumstances and include support to build individual capability and capacity.

Examples of activities that *may* be appropriate could include:

- Engaging with a Personal Helpers and Mentors service or a similar peer support/mentoring programme;
- Participating in a programme of support such as Day to Day Living;
- Meeting with a Disability Employment Consultant or Careers Advisor to discuss possible future employment aspirations or goals; and/or
- Participating in voluntary work at a place chosen by the person.

Providing people with support to boost their employability and build individual capability could aid recovery from mental illness for some people and mutual obligation in and of itself is not inherently bad. However, there are some important caveats that must be put in place in order to ensure that mutual obligation builds the capacity of mental health consumers and carers to participate socially and economically. Most importantly, mutual obligation requirements should be tailored to individual circumstances and aspirations as well as the capacity of those individuals to participate.

RECOMMENDATION 8

Mutual obligation requirements should be:

- Tailored to individual circumstances and promote recovery;
- Proportionate to someone's assessed capacity to participate;
- Targeted towards helping people to address barriers to social and economic participation;
- Focussed on meaningful activity designed to provide employment skills and/or improve social participation and reduce the impact of disability.

In addition, any 'agreed activities' should be determined after a genuine negotiation occurs between a Centrelink worker or an Employment Consultant and the participant; this is not the case at the moment. Instead there is a narrow range of activities that people can 'choose' to undertake in order to meet their 'mutual obligations'. This can result in people feeling pressured or forced to undertake mutual obligation activities that do not meet their needs and/or build employability or, worse, are inappropriate or beyond their capacity to fulfil – leading to penalties for 'non-compliance'.

RECOMMENDATION 9

To increase the likelihood of people meeting any mutual obligation commitments without jeopardising their health and wellbeing, welfare recipients should be afforded greater choice and control over the types of mutual obligation activities they are expected to undertake.

The MHCA and the NMHCCF agree with the Interim Report's proposal to adopt a more individualised approach to mutual obligation.[22] However, insufficient detail is provided that would enable us to understand how this would be operationalized in practice as it would represent a significant departure from the current inflexible approach.

RECENT POLICY CHANGES

While the Interim Report quite rightly asserts the need for individually tailored approaches to mutual obligation that allow for greater discretion and more flexibility, having regard for the barriers to participation that some people may face, elements of Government policy are actually moving in the opposite direction. Recent policy changes standardise, rather than individualise, mutual obligation requirements.

From 2015, Work for the Dole will replace a range of existing approved 'mutual obligation' activities as a singular programme that all people receiving Newstart and Youth Allowance (non-student) must participate in for 26 weeks each year[23]. Rather than tailoring approved activities to the needs of individuals, the approach outlined in the Exposure Draft of the purchasing arrangements for mainstream employment services from 2015 to 2020 would require all people on these payments to participate in the same activity regardless of their individual circumstances or their vocational, education or training needs.

Work for the Dole may be inappropriate for many people with mental illness, some of whom may not be flagged for exemption because they have not disclosed their illness to Centrelink or their employment services provider. The tougher penalties for non-compliance are a cause of significant concern.

In addition, the proposal to deny access to income support entirely for young people aged under 30 who are not in education, employment and training for six months out of reach year cannot be ignored in the context of a broader review of the welfare system. Despite not receiving payments, people subject to this measure will still be required to attend monthly appointments with employment services and meet the same job-search obligations as people aged under 50 who are on a full payment[24].

This would seem to be a 'one way street', rather than 'mutual obligation'; as the Government is not providing an income support payment (fulfilling its obligation) in return for undertaking job search activities. Failure to comply with job-search obligations will result in the additional time being added to the 'waiting period' for income support. Past experience has shown that penalties have been disproportionately applied to people with mental illness.

[22] Department of Social Services, A New System for Better Employment and Social Outcomes: Interim Report on Welfare Reform to the Minister for Social Services, Australian Government 2014, p.81.
[23] Department of Employment, Exposure Draft of the Purchasing Arrangements for Employment Services 2015-2020, Australian Government, 2014, pp. 26-27.
[24] http://www.humanservices.gov.au/corporate/publications-and-resources/budget/1415/measures/job-seekers/64-90066

9. THE IMPACT OF PENALITIES FOR NON-COMPLIANCE

The Interim Report suggests that participation requirements should be accompanied by an appropriate and effective compliance framework. It then goes on to say that 'the current lag between non-compliance and the imposition of sanctions has been criticised for making the system ineffective' and suggests that 'effectiveness might be improved by giving employment services providers greater management of sanctions including suspensions and (non-payment) penalties'[25] .

Currently, these penalties include the loss of a proportion a person's total income support payment for thirteen weeks, the complete loss of payments for eight weeks and suspension and cancellation of payments. Such sanctions are too harsh in our view and would only serve to worsen the health and wellbeing of people with mental illness and/or psychosocial disability if imposed upon them.

There is evidence that these penalties (introduced from 2001 onwards) that were applied to recipients of activity-tested payments who were reported for 'serious participation failures' were disproportionately applied to people with mental illness on the Newstart Allowance, many of whom had not disclosed their illness[26].

Past experience suggests that such penalties can worsen health and wellbeing outcomes and place people's housing at risk[27]. In the worst case scenario the stress caused by the imposition of financial penalties could trigger the need for re-engagement with expensive clinical services.. This would in turn cost government far more than would be saved through the cancellation or reduction of payments.

For these reasons, the MHCA and the NMHCCF caution that if mutual obligation requirements are to be extended to mental health consumers and carers who are currently receiving non-activity tested payments like the Carer Payment or DSP then they must not come with the same harsh sanctioning regime for alleged non-compliance that is imposed on recipients of allowance payments.

RECOMMENDATION 10

Punitive sanctions for alleged 'non-compliance' should not be applied to people with mental illness or psychosocial disability.

The MHCA and the NMHCCF believe that providing incentives to participate and giving due consideration to barriers to participation that may prevent people from meeting 'mutual obligation' requirements on every occasion is a preferable approach to the imposition of punitive sanctions. This could include a financial 'participation supplement' or bonus to reward people for taking steps to improve their capacity for economic and social participation.

[25] Department of Social Services, 2014, op cit. p.81.
[26] http://www.ombudsman.gov.au/files/Falling-through-cracks_customers-with-mental-illness.pdf
[27] http://www.ombudsman.gov.au/files/Falling-through-cracks_customers-with-mental-illness.pdf

RECOMMENDATION 11

Centrelink should offer positive incentives to reward people for undertaking activities that increase their capacity for economic and social participation. This could include a financial 'participation supplement' or bonus payment.

While the MHCA and the NMHCCF support incentives to reward people for participation rather than punitive sanctions for not meeting requirements, worryingly, current Government policy is moving in the opposite direction. Recent changes announced in the budget seek to toughen penalties for 'serious and persistent participation failures' and place what are arguably unreasonable limitations on what reasons for 'non-compliance' are acceptable. Penalties will be toughened and the definition of so-called 'reasonable excuses' for not attending appointments or Work for the Dole tightened to include only reasons that 'directly prevent a job-seeker from attending their appointment'.

People with mental illness stand to be disproportionately adversely affected by these changes. A pertinent example of this would be people with anxiety disorders, for whom it is not always practical to contact their JSA provider in advance. For example, someone's symptoms have escalated to the point that they are simply not able to make contact,, let alone leave the house, coordinate transport to an appointment by a designated time and then engage in a constructive conversation with their JSA provider about their Employment Pathway Plan.

This is the daily reality for many thousands of people with mental illness who receive income support payments.

Furthermore, the 'stronger participation measures for people aged under 30' include the imposition of additional waiting periods (to the 6 months per year without income support) if people fail to meet job-search requirements or attend monthly appointments with employment services.

It is therefore vital that appropriate safeguards are put in place to ensure people with mental illness are not subject to punitive sanctions because their illness has prevented them from meeting participation requirements on a given day.

10. EMPLOYMENT SERVICES

ENGAGEMENT WITH EMPLOYMENT SERVICES BY PEOPLE WITH MENTAL ILLNESS

More than 50,000 people with psychosocial disability are currently engaged with Disability Employment Services and Disability Management Services (DES/DMS) on a voluntary basis[28]. This equates to approximately one third of participants in the DES/DMS programme. In addition, we know that 26% of JSAclients are identified as people with disabilities (approximately 178,000 people)[29]. We do not know how many in this group are people with psychosocial disability, but if it proportionate to the percentage of people receiving the DSP due to psychosocial disability it could be as many as 60,000 people. It is unclear how many mental health carers are participating in employment services.

It is also difficult to quantify how many people engaged with JSA are experiencing mental illness. A significant number of people may not have disclosed their mental illness due to issues such as the stigma that people often experience following disclosure. The issue of stigma is discussed in Appendix D.

As a result many people with mental illness may be engaged with JSA providers but in inappropriate streams. They would be receiving insufficient employment assistance and inadequate support to address non-vocational barriers to employment. Anecdotal evidence is that a significant number of people with mental illness are in stream four[30] but are not receiving any support or treatment, leaving JSA workers to fulfil this role.

Not only is providing such support beyond the job descriptions (and in most cases, the capabilities/skillsets) of employment consultants. This underscores the need for increased collaboration between employment and mental health services to ensure people are receiving the holistic support they need to enable them to lead contributing lives.

With significant numbers of mental health consumers and carers engaged with employment services it is vital that they are designed and resourced to deliver sustainable job outcomes for this group.

THE EFFECTIVENESS OF EMPLOYMENT SERVICES

While high numbers of people with mental illness are engaged with mainstream and disability employment services, employment outcomes for mental health consumers following engagement are poor.

The three most intensive programs achieved job placement outcomes of 26.6%, 24.2% and 18.8% for people with mental health conditions and psychosocial disability[31].

Put another way, between 75% and 80% people with mental illness and psychosocial disability do not secure on-going work following engagement with employment services (either DES/DMS or JSA). This highlights inadequacies in the ability of the employment services system to meet the needs of people with mental illness.

There are a number of factors that contribute to this:

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[28] Department of Social Services, Disability Employment Services, Monthly data, March 2014 (presented at Disability Employment Services Consumer Engagement Consultation, April 2014.

[29] Australian Chamber of Commerce and Industry, Improving Employment Participation by People with Disability: ACCI Submission to Australian Human Rights Commission Inquiry, February 2013, p.10.

[30] The Job Seeker Classification Instrument is used to assign job-seekers to four streams on the basis of readiness to work. Stream 4 is for people deemed least work-ready with multiple barriers to employment.

[31] Orygen Youth Health, Work Education and Young People with Mental Health in Australia: Section 3 – Employment and Mental Illness in Australia, 2014, pp.29-30.

- High caseloads (some employment consultants are working with over 180 clients);
- Employment consultants are forced to spend too much time on compliance/reporting requirements and red tape;
- The Employment Pathway Fund does not provide sufficient brokerage to funds for support to address non-vocational barriers to employment such as those arising from mental health issues;
- Financial incentives and marketing tools such as the star-rating system are skewed towards rewarding providers for short-term job placements rather than sustainable job outcomes, making it more profitable to focus on clients who are job-ready and will deliver the greatest return on investment; and
- Contracts do not encourage, reward or require employment services to work collaboratively with other service providers that may be providing support to a job-seeker. This discourages provision of the 'wrap around' support that the Interim Report rightly suggests can be necessary to support people to recover from mental illness and build individual capability to prepare for and sustain work.

These factors combine to work against people with multiple barriers to employment because the combination of insufficient capacity to deliver personalised support and inadequate financial incentives discourage, and in many cases prevent employment services from providing the range,, intensity or duration of support that mental health consumers need.

These problems are not confined to JSA. They were highlighted in survey responses we received from mental health consumers and carers who shared their experiences with DES/DMS with the MHCA (see Appendix B).

Clearly, new contractual arrangements with employment services models that are largely business as usual will not deliver improved sustainable employment outcomes for mental health consumers and carers regardless of whether or not they are forced to engage with employment services in exchange for receiving income support. The current large scale models are either not effective or are inappropriate for people with mental illness or psychosocial disability.

RECOMMENDATION 12

Outcome payments for employment services providers should be based on the achievement of sustainable employment outcomes (for example, at the 26 and 52 weeks' stage), not short term job placements.

RECOMMENDATION 13

Employment services providers should be funded/resourced to work collaboratively with other services to deliver coordinated support for their clients.

RECOMMENDATION 14

Providers of employment services and other services accessed by people with mental illness, including housing services and community mental health services, should be funded to employ specialist employment consultants with lower client loads to work more intensively with people facing multiple barriers to employment, including people with mental illness and to place those consultants in external agencies where appropriate.

RECOMMENDATION 15

Compliance and reporting requirements should be simplified to free up more time for employment consultants to devote to meeting the needs of job-seekers and employers.

CONSUMER AND CARER EXPERIENCES WITH DISABILITY EMPLOYMENT SERVICES

Mental Health consumers and carers told the MHCA that employment services that effectively support people with mental illness to find jobs and stay employed share the following characteristics:

- People are treated with dignity and respect and do not experience stigma or discrimination;
- Consultants understand the lived experience of mental illness and the impact it can have on preparing for, finding and sustaining employment (ideally consultants would be peer workers);
- Providers work in partnership with other services providing support to a person;
- Pre and post job placement support is provided consistent with duration and intensity of need;
- Personal support is accompanied by support for employers including the provision of 'reasonable adjustments to the workplace';
- Employment consultants engage in advocacy on behalf of people with mental illness;
- Consultants refer people to jobs matched to the vocational area of the client's current skill set or vocational goals determined by the client to reach open employment;
- People's employment/career aspirations and goals are respected;
- Sustainable job outcomes are prioritised over short-term job placements.

Additional insights from the MHCA's consultations with consumers and carersare outlined in Appendix B.

REFORMING EMPLOYMENT SERVICES

It is vital that the views of mental health consumers and carers (including those outlined above) are valued and respected and taken into account when considering how we might go about reforming employment services for their benefit. Reforms that free up the time available to Employment Consultants to support people to undertake activities to boost their employability, look for suitable available work or re-engage in education and training are desperately needed Many people with mental illness and psychosocial disability are likely to need one or more of the following:

- intensive case management;
- vocational or basic skills training;
- work experience in regular employment; and
- Integrated services including employment, health and social support services.

For the reasons outlined earlier, current models (especially JSA) are not sufficiently resourced to deliver the holistic and intensive support that is needed.

Reducing the compliance burden faced by providers could free up the resources needed to pursue alternative employment services models that deliver better sustainable employment outcomes for people with mental illness and psychosocial disability. Rather than replicate existing models, providers should be encouraged and resourced to explore and assess their capacity to do things differently based on what works.

RECOMMENDATION 16

The Australian Government should fund Disability Employment Services to develop and expand best practice models of employment services for people with mental illness and psychosocial disability based on a comprehensive review of what has been shown to achieve the best sustainable employment outcomes for different population groups in Australia and overseas.

In addition, employment services must be resourced to establish and maintain active partnerships and working relationships with allied community, health and social services including mental health and housing providers. This would ideally entail providing 'wrap around' support for people with mental illness as recommended in the Interim Report.

RECOMMENDATION 17

Consistent with proposals in the Reference Group's Interim Report, 'wrap around' support packages for people with mental illness and psychosocial disability should be expanded and address both vocational and non-vocational barriers to employment and social participation.

THE INDIVIDUAL PLACEMENT AND SUPPORT MODEL

One example of an effective model of service and support is the Individual Placement and Support (IPS) model highlighted in the Interim Report[32].

The MHCA has heard many positive stories from consumers[33] and community mental health workers about the success of the IPS model in placing people with severe mental illness in work and providing the right tailored support to assist people to stay employed beyond 26 weeks.

While IPS is not a panacea for supporting people with mental illness to make the transition from welfare to work, comparably high employment outcome rates (over 60% of participants with mental

[32] Department of Social Services, A New System for Better Employment and Social Outcomes: Interim Report on Welfare Reform to the Minister for Social Services, Australian Government 2014, p.105.
[33] Our DES Consumer Engagement Project and Surveys conducted for the purposes of informing this submission.

illness remained employed after 26 weeks) have been observed across multiple sites in a number of countries. Comparison models in the same sites achieved outcome rates of between 20% and 30%[34], similar to those achieved by DES/DMS and JSA for people with mental illness and psychosocial disability[35].

Distinctive features of the IPS model that could account for its success in comparison to other models, including:

- Comparatively low client loads (averaging 30 comparing to up to 180 for JSA);
- IPS locates a particular DES employment specialist within a mental health service (this could include community mental health services or youth specific service models such as Headspace);
- Competitive employment is the goal;
- Personalised benefits counselling is provided;
- The job search starts soon after a person expresses interest in working;
- Employment specialists systematically develop relationships with employers based upon their client's preferences;
- Job supports are continuous;
- Client preferences are honoured; and
- Providers typically have access to more information about a person's circumstances and history than other providers.

The Western Australian Association for Mental Health has developed a useful online resource about the IPS model and its implementation in Australia[36].

RECOMMENDATION 18

Employment services models such as Individual Placement and Support which have demonstrated superior sustainable job outcomes for people with mental illness should be expanded nationally, and embedded into community mental health services where possible.

[34] http://apt.rcpsych.org/content/14/1/50.full
[35] Department of Employment and Department of Social Services data – outcome rates from DES/DMS and JSA.
[36] http://waamh.org.au/development-and-training/projects/individual-placement--support-ips.aspx

11. THE ROLE OF EMPLOYERS

The Report notes that employers play a key role in improving outcomes for people on income support. We offer broad support to all initiatives that promote the creation of additional job opportunities for people with disabilities, including psychosocial disability.

The MHCA and the NMHCCF agree that volunteering can be a very effective pathway to employment for people[37] It can equip working age people with new skills and current experience that can give them an advantage when job-seeking.

Investment in effective incentive-based employment initiatives like wage subsidies paid to employers to hire mental health consumers and carers balanced with support for employers to accommodate the needs of new employees with mental illness or caring responsibilities should be prioritised over programmes such as Work for the Dole that have historically not led to sustainable job outcomes for the overwhelming majority of participants[38].

The MHCA and the NMHCCF agree with the Interim Report's recommendation that employers should be encouraged and supported to make jobs available for disadvantaged groups including people with disabilities and mental illness[39]. To do this it is necessary to increase awareness of the benefits of employing people with disabilities and mental illness and dispel some of the misconceptions and myths that may discourage employers from making jobs available to this group.

RECOMMENDATION 19

The Australian Government should fund an awareness campaign and wage subsidies to encourage employers to hire people with mental illness and psychosocial disability and promote the value of increased workplace diversity**.**

While private enterprise and the third sector have a significant role to play in making more jobs available to people with disabilities arguably the public service should show leadership in this area.

RECOMMENDATION 20

The Australian Government must show leadership in the employment of people with disability by increasing the proportion of people with disability employed in the public service from 3.8% to at least the 1986 level of 6.6% by 2020.

[37] Department of Social Services, Interim Report, op cit, p.115
[38] http://cf.fbe.unimelb.edu.au/staff/jib/documents/wfdwp.pdf
[39] Ibid, p.95

12. INCOME PROTECTION INSURANCE

Insurance – and most relevantly, income protection insurance – is a potentially important source of both financial and labour market support for people with mental illness.

Income protection insurance provides benefits in the event that a person is unable to work following an accident, illness or major trauma. Insurance and superannuation providers also play an important role in working with employers to assist people to return to work after a period of absence. Income protection insurance is available by default through most employee superannuation schemes, and can also be obtained through the private market.

Unfortunately, many people with experience of mental illness are unable to access the benefits and supports of income protection insurance. On the basis of a prior history of mental illness, many people are forced to pay increased premiums, have applications and claims rejected, or are excluded from cover all together, regardless of whether the claim is related to mental illness or not.

The stories that the MHCA has heard over many years suggest that some insurance policies or practices – including in income protection insurance – are unfair and possibly contrary to anti-discrimination legislation.

The Disability Discrimination Act 1992 (Cth) (as well as equivalent state/territory legislation), enables insurers to discriminate against people with mental illness, so long as the discrimination is reasonable having regard to actuarial or statistical data on which it is reasonable to rely and 'other relevant factors'.

However, due to the proprietary nature of actuarial judgments, it is impossible to determine whether insurers do in fact possess data that would enable a reasonable assessment of risk to be made. We are yet to see evidence that such data exist, and have seen notable evidence to the contrary.

In many cases, the barriers to insurance faced by people with mental illness could be removed through simple steps, such as better designed insurance products and better understanding of mental health issues by insurance underwriters and frontline staff. In other cases, the solutions are not clear, because of the complexity of the risk assessment process. Further, reasons for decisions are often not disclosed or are communicated very poorly.

For people with experience of mental illness who may periodically require absences from work, fairer access to income protection insurance could provide better job security and peace of mind, as well as financial support in lieu of paid work drawn from outside the welfare system.

RECOMMENDATION 21

The Government should engage with insurance and superannuation providers, as well as relevant regulatory bodies and mental health consumers and carers, on innovative and constructive approaches to income protection insurance to provide better support for people with mental illness to maintain and return to work.

13. NATIONAL DISABILITY INSURANCE SCHEME

The report suggests that the introduction of the NDIS will free up opportunities for ‘many carers’ to participate in paid work or programmes to improve their prospects of getting work when ‘their caring role ends’.

Unfortunately in the case of people with psychosocial disability, the number of people likely to be eligible for ‘tier 3’supports through the NDIS (which might fund formal care) represents only about 20% of the group of people currently receiving the DSP due to psychosocial disability.

While the NDIS takes account of the availability of natural or family supports when determining what supports it will fund. it is too early to say whether or not the NDIS act as a catalyst for a significant number of carers to undertake employment or structured work preparation activities. It is therefore extremely premature to use the future implementation of the NDIS as a reason for cutting Carer Payment or limiting access to the DSP.

APPENDIX A: BENEFITS AND RISKS OF WELFARE REFORM

BENEFITS OF A HIGH FUNCTIONING WELFARE SYSTEM

A high functioning welfare system that supports people with mental illness and psychosocial disability effectively would deliver the following benefits for **mental health consumers and carers**:

- Less confusion, frustration and stress associated with accessing and navigating the system;
- Providing an adequate income regardless of what work capacity someone is deemed to have;
- Timely access to the right payments and support services to support people to recover from mental illness and assist them to lead contributing lives;
- Support for those with actual or potential capacity to work to overcome barriers to employment; and
- Increased social and economic participation, improved social skills and relationships, greater confidence and resilience, and increased financial independence.

A high functioning welfare system that supports people with mental illness and psychosocial disability effectively would deliver the following **social and economic benefits**:

- Increased labour force participation by mental health consumers and carers, enhancing the productive capacity of the economy and stimulating economic growth;
- Addressing current and projected workforce shortages by providing education, training and up-skilling for mental health consumers and carers, including through identified roles in mental health settings;
- Improving the responsiveness of the workforce to emerging labour market opportunities;
- Enhancing workforce and workplace diversity, driving innovation and productivity gains at the organisational level;
- Improved social connectedness and community resilience; and
- Reduced rates of social and economic exclusion, contributing to greater tolerance and less discrimination and stigma against people with mental illness.

A high functioning welfare system that supports people with mental illness and psychosocial disability effectively would deliver the following benefits for **government**:

- Reducing overall expenditure on income support over the long term, by providing more incentives for mental health consumers and carers to work as and when they are able;
- Increased revenue from personal income tax through increased workforce participation by mental health consumers and carers not currently in the labour force;
- Reduced expenditure across the health and social services systems as a result of improvements to the health and wellbeing of people with mental illness and psychosocial disability;
- Increased community confidence in the effectiveness and sustainability of the income support system and related social services; and

- Reductions in the costly burden of administration, compliance and red tape through redesigned employment services, simplified payment structures and better integration between the welfare and other service systems.

RISKS IN NOT DELIVERING THE RIGHT REFORMS

The review being led by the Reference Group on Welfare Reform presents a potential 'once a generation' opportunity to reform the system for the benefit of mental health consumers and carers. Equally there are significant risks if the new system does not deliver the right reforms.

These Include:

- Consigning people with severe and persistent mental illness and carers to a lifetime of social and economic exclusion;
- Failing to improve Australia's comparatively low rates of participation in education, employment and training by people with on-going mental illness and psychosocial disability;
- Missing an opportunity to take concerted and constructive action to address intergenerational disadvantage, labour market exclusion and poverty;
- On-going ineffective and inefficient government spending much of it on initiatives and programmes that are delivering sub-optimal outcomes;
- Retaining current systemic flaws that serve to discourage participation by many people and mandate often ineffective 'participation for participation's sake' measures by others;
- Perpetuating a payment structure characterised by inadequate payments and arbitrary and out-dated disparities between payment levels on the basis of designated classes of recipients and capacity to work/study rather than on need;
- Continuing with modified versions of current service delivery approaches and models that are achieving sub-optimal employment outcomes for those most in need; and
- Not getting employers (private, public and community sectors) on board with new directions for our welfare system and potentially missing opportunities for better integrating the income support, employment services, University and VET sectors with employers and labour market opportunities.

APPENDIX B: CONSUMER AND CARER FEEDBACK

The following is a summary of the main themes in response to key questions from surveys of mental health consumers and carers about life on DSP/Carer Payment and experiences/interactions with the welfare system and their experiences with DES.

The findings from these surveys have been used to inform the content of our submission.

IS IT HARD TO MAKE ENDS MEET ON THE DSP OR CARER PAYMENT?

- The vast majority of respondents told us that it was difficult for them to do any more than meet the basic costs of week to week living on either the DSP or Carer Payment.
- Housing was singled out as a major cost pressure by recipients of both payment types with many people allocated more than one third of their income support payment to rent/mortgage repayments.
- Other significant expense items were the costs of support and treatment associated with disability and/or illness, utilities and transport (especially for those outside of cities.
- Unexpected expenses led to many people having to borrow money from family/friends or financial institutions and going into debt as a consequence;
- No-one reported that they had a capacity to save.

IS THERE ANYTHING YOU WOULD CHANGE ABOUT THE WAY CENTRELINK SUPPORTS YOU?

SYSTEMIC CHANGES

- The system is too complex and needs to be simplified;
- Payments are inadequate and should be increased;
- Rent assistance is inadequate and needs to increase in line with cost of housing;
- Better recognition of the episodic nature and other impacts of mental illness on capacity to work and more flexibility to move on and off DSP payments to feel more empowered to work;
- Build a culture of trust rather than suspicion;
- Improved client management systems so people only have to tell their stories once;
- Greater awareness of how co-occurring disabilities affect people;
- Greater recognition that caring is a full time and very demanding job;
- Increased training to assist frontline staff to understand the realities carers face;
- Change taper rates to increase the incentive to work.

OPERATIONAL CHANGES

- Reduce waiting times (both in shop-fronts and on the phone);
- Treat customers with dignity and respect and be less judgemental (like people, not numbers);
- Implement a responsive e-mail enquiry system;
- Better training for frontline staff to assist people with disabilities and mental illness – to reduce the stigma experienced by Centrelink and JSA customers;

- Increase the number of social workers who can spend adequate time with people and secure referrals to community mental health services;
- A reduction in paperwork, compliance and the volume of correspondence.

IF CIRCUMSTANCES ALLOWED, WOULD YOU PREFER TO WORK?

- Unsurprisingly the overwhelming majority of recipients of both Carer Payment and the DSP told us they would prefer to be working.

WHAT SUPPORT WOULD YOU NEED TO BECOME JOB READY AND GET AND KEEP A JOB IF THAT'S WHAT YOU WANTED TO DO?

PEOPLE ON DSP

- Access to better quality, coordinated mental health care and support;
- A supportive and understanding employer/work environment with appropriate adjustments;
- Leave entitlements that are sufficiently flexible to accommodate the need to take time off frequently and unpredictably;
- Support from a mentor or peer-worker;
- Access to appropriate education and training with support to stay engaged; and
- A reduction in stigma and a belief that colleagues will accept people with lived experience of mental illness.

PEOPLE ON CARER PAYMENT

- Leave entitlements that are sufficiently flexible to accommodate the need to take time off frequently and unpredictably;
- Access to respite to enable carers to be confident that the person they care for will be safe/looked after – without respite concentrating on work is difficult/impossible;
- Employers who truly understand the demands and unpredictability of the caring role and its impact on hours of work;
- Support to re-enrol in education or undertake training to update skill-sets;
- Access to Disability Employment Services to support carers to find suitable jobs; and
- Caring responsibilities to diminish to the point that part-time work is realistic.

WHAT CONSUMERS AND CARERS TELL US WORKS WELL

The MHCA recently completed an engagement project with consumers and carers on their experiences with DES/DMS. Consumers and carers who shared their positive experiences with DES/DMS told us that employment services work well when:

- Consumers are treated with dignity and respect and are offered strengths based support;
- Providers work in partnership with other support services ('wrap around support');
- Communication is open and honest and expectations of the provider and the 'job-seeker' are clear and realistic;
- Services are able to provide pre and post-employment support for the duration of need;

- Liaison with employers occurs pre and post-employment;
- Consultants engage in advocacy on behalf of people with mental illness;
- Assistance with job applications is tailored to the aspirations of the 'job-seeker' and matches jobs to skills and experience; and
- The goal is a sustainable employment outcome, not a short-term job placement.

WHAT CONSUMERS AND CARERS TELL US DOES NOT WORK WELL

Conversely, we sought feedback from consumers and carers whose experiences were not positive. They told us, employment services did not work well for them when:

There was a lack of continuity of support;

- Consultants displaced a lack of understanding about the impact of mental illness and psychosocial disability on preparing for, securing and sustaining employment;
- Services were not recovery-oriented or strengths based;
- Centrelink and DES recommendations/expectations did not match up;
- People were not actively assisted to find work;
- Consumers were referred to inappropriate jobs;
- Participants were discouraged from enrolling in education and vocational training;
- The level of funding for support and work preparation activities was inadequate; and
- There was a lack of clarity about support on offer and expectations of the provider and the participant.

WHAT CONSUMERS AND CARERS TELL US NEEDS TO CHANGE

We also asked consumers and carers to tell us what they believe needs to change in order for employment services to better support mental health consumers to prepare for, secure and sustain employment. They told us:

- Increased awareness and understanding of mental illness is needed (by both employment consultants and employers)
- Employment services need to establish constructive relationships with prospective employers of people with disability;
- Continuity of relationships pre, during and post-employment would increase the likelihood of sustainable job outcomes (26 and 52 weeks);
- Embedding employment services in community mental health organisations (they gave the example of the Individual Placement and Support model);
- A stronger emphasis on stigma reduction, including post placement;
- Clear and realistic expectations upon engagement with employment services;
- Pre and post-employment support for the consumer and the employer;
- A supportive work environment is essential to building confidence in the ability to 'fit in' and keep working;
- Mentoring and peer support delivered by people with lived experience who have made the transition to work can give people the confidence necessary to overcome barriers to sustaining employment.

APPENDIX C: WHAT IS STIGMA?

The Report notes that employers play a key role in improving outcomes for people on income support. The report urges reforms to engage with employers. What it is not covered in the Report – specifically – is stigma and its impact on the person with a disability – who may also be receiving income support. The section of the report dealing with "employer attitudes" imports some of the negative aspects of stigma into the discussion, although it is not specifically "named" as such.

The literature refers to stigma as a mark or sign of disgrace usually eliciting negative attitudes to its bearer. If attached to a person with a mental disorder it can lead to negative discrimination[40].

There can be behavioural consequences of stigma which act to the disadvantage of people who are stigmatised[41]. Discriminatory behaviour by employers, services and the broader community can have devastating effects upon the lives of people with disabilities[42]. The rejecting behaviour of others may bring greater harm than the primary condition itself.

I refer to the website for the Mental Health Commission of Western Australia which sets out aspects of stigma[43]

> "Three out of four people with a mental illness report that they have experienced stigma. Stigma is a mark of disgrace that sets a person apart. When a person is labelled by their illness they are seen as part of a stereotyped group. Negative attitudes create prejudice which leads to negative actions and discrimination.
>
> Stigma brings experiences and feelings of:
>
> - shame
> - blame
> - hopelessness
> - distress
> - misrepresentation in the media
> - reluctance to seek and/or accept necessary help
>
> Families are also affected by stigma, leading to a lack of support. For mental health professionals, stigma means that they themselves are seen as abnormal, corrupt or evil, and psychiatric treatments are often viewed with suspicion and horror.
>
> A 2006 Australian study found that:
>
> - nearly 1 in 4 of people felt depression was a sign of personal weakness and would not employ a person with depression
> - around a third would not vote for a politician with depression
> - 42% thought people with depression were unpredictable
> - one in 5 said that if they had depression they would not tell anyone
> - nearly 2 in 3 people surveyed thought people with schizophrenia were unpredictable and a quarter felt that they were dangerous."

[40] G. Thornicroft, D. Rose, A. Kassam and N. Sartorius; "Stigma: ignorance, prejudice or discrimination" *British Journal of Psychiatry* (2007) pp. 190-3.
[41] [41] L. Sayce, *From Psychiatric Patient To Citizen: Overcoming Discrimination and Social Exclusion*, Palgrave Macmillan, 2000.
[42] [42] L. Sayce, *From Psychiatric Patient To Citizen: Overcoming Discrimination and Social Exclusion*, Palgrave Macmillan, 2000.
[43] http://www.mentalhealth.wa.gov.au/mental_illness_and_health/mh_stigma.aspx

For the current report to be in anyway meaningful in its desire to ease the path for income support beneficiaries to employment, it must reflect the practical lived experience of the people affected and it must come to grips with the notion of stigma.

The recommendations arising from this Report must also set out practical steps to deal with stigma in the work place and in the broader community.

Mental Health
Council of Australia

Mentally healthy people, mentally healthy communities