ABSTRACT

There is an increasing recognition that welfare recipients facing significant disadvantage in the labour market are not being well assisted by conventional labour market programs. Often such job seekers struggle against an interaction of employment and educational barriers combined with a range of personal issues such as mental health problems, substance abuse, criminal records, physical health problems, homelessness, and family breakdown.

While there is agreement on the need to provide additional support there is little consensus about what form this should take and whether it can be added to existing programs or requires the development of new initiatives. It is also not clear whether individuals facing personal barriers should be encouraged or required to engage in vocational activities at the same time as addressing personal barriers or whether personal barriers should be addressed prior to providing employment assistance.

This paper explores the labour market outcomes for people facing severe personal barriers to employment in Australia the US and Europe. It then considers whether such people want to work, whether work is beneficial or detrimental and examines current policy responses and gaps. The final section of the paper draws primarily on US research to document program elements and models that have been successful in achieving improved employment outcomes for this group.

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Introduction
There is a growing recognition internationally that welfare recipients facing the greatest disadvantage in the labour market are not being well served by conventional labour market programs. Research indicates that the dominant work-first approach—emphasising rapid employment placement, short-term job skills training, work mandates and penalties for non-compliance—is able to achieve positive outcomes with only a small fraction of the most disadvantaged clients (Dillon, 2004; ESU, 2000; Pavetti et al., 1997; Prairie Research Associates, 2000). Programs with a longer term focus on skill development have also struggled to assist clients facing personal barriers into employment (Kemp & Neale, 2005).

In addition to low levels of education and employment experience, people in this group often face a range of personal barriers that impede their movement into competitive employment. These include mental health problems, physical health problems, drug and alcohol abuse, family breakdown, homelessness and social isolation. Some research indicates that traditional employment programs may actually be detrimental for these clients by pushing them off welfare but not into employment (Pavetti et al., 1997), resulting in increased poverty and exclusion. Clients with a mental health problem, substance abuse disorder, or that have recently experienced domestic violence have been found two to four times more likely to be sanctioned (Danziger & Seefeldt, 2002; Goldberg, 2002) and other research has indicated that those with mental health problems are at risk of not being able to comply with harsher welfare-to-work rules (Johnson & Meckstroth, 1998).

Barriers to employment
Traditionally research looking at barriers to employment has focused on individual barriers linked to human capital (skills, education and work experience) and demographic characteristics, or structural barriers such as childcare, transport, and job availability (Butterworth, 2003a; Jayakody & Stauffer, 2000). While these have been shown to be important in predicting welfare exits and recidivism, recent research has documented the important role of personal barriers in preventing participation in the labour market (Nam, 2005). Seefeldt and Orol (2004) suggest that the combination of personal barriers and human capital characteristics are more important in predicting medium and high levels of welfare accumulation than demographic factors.

In their early work Olsen and Pavetti identified eight personal barriers that had the potential to affect labour market participation:

- mental health problems
- substance abuse problems
- housing instability
- physical disabilities and/or health limitations
- domestic violence
- involvement with the child welfare system
- health or behavioural problems of children
- low basic skills and learning disabilities (Olson & Pavetti, 1996).

Research looking at long-term US welfare recipients (Social Research Institute, 1999) found that a large proportion faced severe, persistent and multiple barriers and that 92% faced at least one severe barrier. A number of other studies have found personal barriers to be associated with increased time on welfare and faster returns to welfare (Derr, Hill & Pavetti 2000; (Nam, 2005; Pollack et al., 2002; Seefeldt & Orzol, 2004; Social Research Institute, 1999).
Mental health problems
One of the most common barriers to employment amongst long-term welfare recipients is mental health problems and mental illness. Studies in the US indicate that between 35% and 45% of welfare recipients have a clinically diagnosable mental disorder (Brown, 2001; Butterworth, 2003b). In France, the rate of mental disorders such as psychoses and depression in welfare recipients has been found to be five times the rate in the general population. (Kovess et al., 1999). In Australia Perkins (2005) found that 78% of participants in an employment program assisting unemployed people with personal barriers faced some type of mood disorder, anxiety disorder or personality disorder and amongst long-term welfare recipients Butterworth (2003b) found that 57% reported depression and that around 15% suffered from post-traumatic stress disorder.

Clients with mental health problems are more likely to receive welfare, and for a longer time, to have significantly higher unemployment rates, lower labour force participation, lower earnings and reduced work hours (Jayakody & Stauffer, 2000; Johnson & Meckstroth, 1998; Social Research Institute, 1999) (Waghorn & Lloyd, 2005). Mental health problems have also been shown to increase the risk of sanctioning and be associated with more rapid returns to welfare (Jayakody & Stauffer, 2000; Nam, 2005). Reviewing the literature Derr et al. found that post-traumatic stress disorder, major depression and generalised anxiety all significantly increased the likelihood of long-term welfare receipt (2000). However, despite these strong associations, a significant number of those with mental health problems and severe mental illness do participate in employment. However, this is highly correlated with level of education (Jayakody & Stauffer, 2000).

Given the high prevalence of mental health problems amongst long-term welfare recipients and those facing personal barriers, effective mental health support is a crucial element of improving employment outcomes.

Desire to work
Despite the poor aggregate employment outcomes for welfare recipients facing mental health problems and other personal barriers, evidence from a range of research suggests that a large proportion of this group wants to be in employment. In an Australian study with long-term unemployed people facing an average of 9 personal barriers, 74% listed work or education as the activity they would most like to be doing now (Perkins, 2005). In the UK, Singh (2005) reported that 77% of homeless people wanted to work now and that 97% wanted to work in the future. Reviewing the research for people with mental health problems Evans (2000) asserts that there is an ‘overwhelming consensus from surveys, cases studies and personal accounts that users want to work’. A substantial proportion of people with mental health problems including those with serious mental illness report wanting to work, see employment as feasible, important to their recovery, and as an often unmet need (Bond, 2004; Waghorn & Lloyd, 2005).

However, it is also important to note that there is a significant proportion of clients facing personal barriers who do not feel able to cope with the demands of work (Perkins, 2005), do not see it as important or have other preferred roles such as parenting, studying, caring for family members or volunteering (Shaheen, Williams & Dennis, 2003) (Waghorn & Lloyd, 2005).

Policy responses and gaps
Policy responses to assist welfare recipients facing severe or multiple personal barriers have tended to recognise the failure of ‘work first’ approaches and the need for additional services to assist such people to move towards employment. However, there is significant variation in the approaches and program objectives. These range from simply adding screening and referral mechanisms to existing welfare to work systems, to designing specific programs and employment initiatives (Perkins & Nelms, 2004). Important differences include the extent to which programs require participants to address personal barriers and undertake work activities simultaneously or address personal barriers before undertaking employment-focused activities (Brown, 2001; Prairie Research Associates, 2000).
Prompted partly by the 5-year lifetime limits on the receipt of federal income support, programs in the US have generally maintained a strong emphasis on rapid movement into work for all but the most disabled of welfare recipients, but incorporated activities such as treatment or personal support, as well as a greater emphasis on links with local support agencies (Brown, 2001; Office of Inspector General, 2002). In Australia, the main national program assisting unemployed people facing severe or multiple personal barriers to employment operates from outside the regular welfare to work system. It provides case-managed support for a two-year period to address personal barriers and increase economic or social participation. Clients are exempt from regular activity test requirements and there is minimal emphasis on moving into employment (Perkins, 2005). In Europe measures funded by the European Social Fund under the EQUAL initiative have the aim of ‘facilitating access and return to the labour market for those who have difficulty being integrated or reintegrated’. Projects aim to integrate different types of expertise and services to address personal and vocational barriers and achieve vocational and personal or quality of life outcomes (ESU, 2001).

Other measures address personal barriers by moving people outside the welfare to work system into alternative programs focused on specific barriers such as substance abuse counselling, homelessness support services or mental health support. Often people in these groups are exempt from activation requirements and receive little or no vocational assistance. Others may receive a disability pension or, as is the case in Australia, be given exemptions from welfare to work programs and activation requirements after providing a medical certificate, often resulting in no systematic support at all.

Problems

Despite the universal goal of increasing participation in employment and evidence that a large proportion of jobseekers with severe personal barriers want to move in to employment, there is currently a lack of research about the models and interventions that can best assist this group to do so. Evidence suggests limited success of both the enhanced work first approach and the alternative barrier specific programs, indicating the need for programs that can better integrate the provision of targeted vocational assistance and personal support.

Traditional welfare to work approaches (emphasising job skills training and rapid employment supplemented with referrals to support services) seem unable to provide appropriate vocational interventions and comprehensive support required to reconnect people facing serious personal barriers to the labour market (Jayakody et al., 2004). As Dillon (2004, p.2622) comments, ‘Traditional job counselling approaches, at least as they are typically applied, seem grossly inadequate for chronically unemployed individuals with serious barriers’.

Amongst barrier focused interventions such as substance abuse programs, mental health services, or general case management programs often there is a failure to recognise the significance of work, a tendency to focus on impairments (Evans & Repper, 2000; Marrone & Golowka, 1999), a lack of awareness of labour market opportunities (Richards & Morrison, 2001); and vocational assistance is absent, poorly defined or of variable quality (Blankertz & Magura, 2004). Research looking at people with mental health problems suggests that case management in the absence of specific vocational efforts will have little impact on employment (Bond, 2004).

A further problem with these approaches can be attitudes of professionals and support staff that participants should not be encouraged to work, a misplaced desire to ‘protect’ the vulnerable clients (Evans & Repper, 2000), and an unsubstantiated belief that employment is not realistic and could have an adverse impact on the participants mental health or well-being (Waghorn & Lloyd, 2005).
Benefits of employment

Work is able to provide income, status, social interactions and a means of participation in society. It is an important determinant of social inclusion and some suggest that it should be viewed as an entitlement and citizenship issue (Evans & Repper, 2000).

Marrone and Golowka (1999) argue that given the range of evidence suggesting that people with mental health problems can work, it should be viewed as both a right and a responsibility. However, they caution that such a stance is not intended to deny the real barriers people face or advocate a ‘get tough’ approach, but to place greater accountability on government and program staff to ensure appropriate support.

Even for people with severe mental illness, appropriate competitive employment has been found both to be feasible (Drake et al., 1999) and not to be detrimental or exacerbate mental health problems (Marrone & Golowka, 1999). In fact, there is some evidence that engagement in competitive employment can provide benefits to individuals facing personal barriers (Honey, 2004).

A range of studies have obtained qualitative reports of the high value that diverse participants place on moving into work. Anderson et al. (2004) found that women facing personal barriers in Chicago reported psychological benefits from work, work as a source of pride in accomplishment and the workplace as somewhere to form new friendships. Among people with mental illness Auerbach and Richardson (2005) found that, in addition to providing a personal gain, work contributed to a person feeling ‘normal’, that it could act as an antidote to problems (chaos, depression, boredom), a way to help people organise their lives, a conduit to personal growth and means for the development of competencies. Homeless unemployed people in the UK reported that the benefits of work included improving self esteem, creating a sense of purpose, improving mental well-being, providing independence and a part in mainstream society and assisting in breaking the dependency culture (Singh, 2005). Other benefits reported by participants include regular activity, a sense of purpose, improved mental health, self-esteem and self image (Honey, 2004). For some people work is also closely linked to their experience of recovery (Provencher et al., 2002).

However, participants have also reported negative elements in their experiences of work such as restrictions on other activities, problems adjusting to the routine of employment, negative social experiences, stress, and experiences that reduce self-esteem (Honey, 2004). These point to the need for ongoing support as well as careful choice of jobs that can maximise potential positive effects and minimise negative effects. Some researchers have suggested that a proportion of individuals are also likely to require transitions steps that provide opportunities for personal growth and developing work skills before moving into competitive employment (Waghorn & Lloyd, 2005).

Empirical evidence regarding the benefits of work for people facing significant personal barriers is not consistent, but a number of studies have reported positive impacts, and none have reported overall negative impacts from competitive employment. Among welfare recipients with mental health issues employment has been associated with increased self esteem and a lower level of symptoms; however causality is not always clear (Honey, 2004). Among clients with substance abuse issues Shepard and Reif (2004) found that employment could lead to improved psychological functioning, motivation for recovery, reduced depression and improved social functioning. In Australia participation in vocational activities for people receiving assistance through government rehabilitation services was associated with reduced clinical symptoms and higher levels of functioning (Waghorn & Lloyd, 2005). Gaining work has also been linked to realistic rather than negative appraisals of the future (Evans & Repper, 2000) and amongst homeless people the move into employment has been linked to improved health outcomes (Singh, 2005).
Other benefits
Some studies have also found that employment or vocational rehabilitation can assist participants in overcoming other barriers. Benefits for recovering drug users have included aiding the process of recovery from substance abuse (Becker, Drake & Naughton, 2005; Richards & Morrison, 2001), motivating the control of substance abuse (Becker, Drake & Naughton, 2005), reduced levels of drug use (Shepard & Reif, 2004), and an increased likelihood of employment after discharge from the program. In a US study of drug-using women Atkinson and Montoya (2003) identified a cycle where being employed in one time period reduced the likelihood of using drugs in the following time period, which in turn resulted in reduced levels of distress. This improvement could then lead to an increase in the number of hours worked and to further reductions in distress. Shepard and Reif (2004) formalise such a model and suggest that appropriate vocational interventions can have direct positive impacts on employment competencies, other competencies and drug use.

Unemployment and depression
An additional argument for integrating people with personal barriers into employment is the connection between unemployment and poorer mental health and well-being. While some of this association is likely to come about through people with mental health disorders being more likely to become unemployed in the first place, there is strong evidence for unemployment being causally related to poorer mental health (Mathers & Schofield, 1998). Australian research has indicated that unemployment has a negative impact on mental health and can impede a move back into employment (Ganley, 2002). Analysis of data from the Australian Longitudinal Survey also indicated that unemployment was causally linked to a 50% increase in psychological disturbance (Flatau, Galea & Petridis, 2000). Overseas studies have reported similar results. Clarke and Oswald (1994) in the UK found that unemployment had a statistically significant adverse effect on mental well-being and Winkelmann and Winkelmann (1998) found that unemployment resulted in negative impacts on life satisfaction. There is also more limited evidence that unemployment can contribute to reduced mental health or well-being through the associated loss of income (Flatau, Galea & Petridis, 2000; Honey, 2004).

Types of employment assistance/what works
Given the evidence that unemployed people facing severe or multiple personal barriers are not being well served by existing employment assistance programs; that many people in this group have a strong desire to work; and that appropriate work can offer mental health, well-being and other benefits, developing more effective policy responses is critical to helping people in this group to achieve inclusion in the labour market. To accomplish this it appears that new employment interventions will be needed, to cater for particular problems and needs of these clients. Given the high rate of mental health problems, it seems necessary to look to vocational research in the mental health field in the development of new policy responses.

General program elements
Research looking at programs assisting clients facing severe personal barriers has identified a number of elements contributing to achieving employment outcomes. Looking at US programs assisting homeless people with mental health problems Shaheen et al. (2003) found that two themes emerged across all programs: a belief in the value of work at the earliest possible stages of recovery as an aid to the recovery process, and a recognition that a job can help people develop motivation to change, dignity and self-respect. They found that five key factors were related to program success regardless of the model used: an organizational climate and culture that supported work; facilitation of employment; emphasis on consumer preferences and strengths; ongoing, flexible, individualized support; and re-placement assistance. Other program elements included the need to be flexible in the measure of outcomes, endorsement of employment success at any level, and providing long-term support.
Brown (2001) reported that vocational elements associated with successful programs assisting clients with multiple personal barriers included working closely with employers, finding jobs that provide a supportive environment; continuing support after employment; and, help with upgrading skills to advance to better jobs.

Generally assisting people into jobs quickly and developing skills appropriate for the work environment, the place-train approach, has been found to be more effective than pre-employment programs that develop skills before searching for and placing people into employment, the train-place approach (Shaheen, Williams & Dennis, 2003). However some projects have reported greater success when participants are able to gain a credential in a training component (Philbin, 2003).

Pavetti and Kauff (2006) suggest that there is a strong need for programs working with unemployed people facing multiple barriers to provide ‘developmental work opportunities’ that build marketable skills, provide participants with gradually increasing responsibility, identify flexible tasks matching individual’s strengths and limitations; and, provide ongoing supervision in a nurturing environment.

Other program elements identified as effective in assisting this client group include:

- providing a variety of activities appropriate to individuals at different times (Brown, 2001; Richards & Morrison, 2001)
- a knowledge and understanding of the local labour market (Richards & Morrison, 2001)
- use of financial incentives to increase the take-up of work (Butcher, 2006; Drebing et al., 2005)
- intensive assessment and goal-setting process with other participants (Philbin, 2003)
- employment specialists spending more time out of the office assisting participants (Bond, 2004)
- high expectations in goal achievement and lifestyle advancement (however this should initially be borne by support staff) (Marrone & Golowka, 1999; Richards & Morrison, 2001)
- utilising staff with specific vocational expertise (CalWORKs Project, 2001)
- providing peer support and mentoring (CalWORKs Project, 2001)
- small case loads of up to 25 (Shaheen, Williams & Dennis, 2003)

Integration of employment and support services can improve employment outcomes (Shaheen, Williams & Dennis, 2003) and there is evidence from mental health programs that treatment and vocational plans that are not integrated can actually be detrimental, causing mutual interference and negatively affecting progress in both domains (Waghorn & Lloyd, 2005).

Indicators of program elements that may be important can also be gained from clients’ views. Amongst people with mental illness, Alverson et al. (1998) found that valuing the maintenance of one’s mental health and physical functioning; belonging to and actively participating in functional social groupings, friendship networks or voluntary associations; and the absence of unrelenting dire poverty were all correlated with moving into employment. Amongst homeless people with multiple barriers in the UK, Singh (2005) found that further training, work experience and volunteering were viewed as the most helpful starting point in achieving work.

**Models of vocational assistance**

In addition to the range of programs trialling individually developed combinations of employment assistance, there are a number of employment models that have the potential to help job seekers facing severe personal barriers. A model based approach allows for consistency in service delivery, the ability to replicate and develop and evaluate individual components (Blankertz & Magura, 2004).
The supported work model

The supported work model has been developed in the US, primarily with clients suffering from mental health problems and severe mental illness, but its use is now being extended to other populations such as substance abuse clients. The model is a ‘place-train’ approach based on the following principles:

- eligibility based on consumer choice (no one is excluded)
- integration of vocational rehabilitation with mental health care
- a goal of competitive employment
- rapid commencement of job search activities
- services based on consumer preferences
- continuing support to retain employment
- advice about changes in income support entitlements (Waghorn & Lloyd, 2005)

Despite the emphasis on immediate placement in competitive employment, there is also a recognition that clients will have changing needs over time and some programs aim for time unlimited and flexible support (Bond, 2004).

In the US research has consistently found that the supported work approach is more effective than previous approaches such as transitional employment in helping participants gain competitive employment (Evans & Repper, 2000; Salyers et al., 2004). Comparing supported employment with pre-vocational training in 12 sites in the US Crowther et al. (2001) found that those in supported employment were more likely to be in competitive employment at 12 months (34% compared with 12%), and on average earned more and worked more hours per month than those who had prevocational training.

Supported employment programs have also achieved successful results with people with substance abuse problems (Dillon et al., 2004) and those with concurrent substance abuse and mental health problems. Becker et al. (2005) report the following guidelines for the development of supported employment programs with dual diagnosis clients: encourage employment; understand substance abuse as part of the vocational profile; find a job that supports recovery; help with money management; and use a team approach to integrate mental health, substance abuse, and vocational services.

Studying practices differentiating high and low performing supported work programs for people with mental health problems Gowdy et al. (2003) found that programs with low placement rates in competitive employment tended to leave it to clients to initiate conversations about work, emphasise pre-vocational over vocational assistance, have delays in vocational assessments, pursue a narrower range of job opportunities, have less frequent employer contact and provide less ongoing support once clients were placed in employment.

Individual placement and support

The Individual Placement and Support (IPS) model is a particular type of supported employment model that recognises the complex ongoing support needs of people with mental illness and addresses these in tandem with vocational support to achieve competitive employment outcomes (Shaheen, Williams & Dennis, 2003). The IPS model includes employment specialists as part of the case management or mental health team, emphasises integration of vocational and clinical services, conducts minimal preliminary assessments, and considers work part of the participant’s ongoing treatment regimen.

The key principles of the IPS model include:
• services focused on competitive employment
• consumer choice so no-one is excluded
• rapid job search, not lengthy pre-employment programs
• integration of rehabilitation and mental health professionals (who still retain their identity as separate practitioners)
• attention to consumer preferences in type of work
• time unlimited and individualised follow-up
• benefits counselling (Bond, 2004).

Reviewing the evidence for these components Bond (2004) found strong evidence for the first four of these components, moderate evidence for the fifth and weak evidence for the sixth and seventh.

In a review of 12 randomised control studies, nearly two-thirds of those people assigned to the IPS model attained competitive employment compared with less than a third of those assigned to other vocational programs (Drake, Bond & Rapp, 2006). Similar results have been obtained in many other studies, where IPS clients have obtained competitive employment faster, had a greater number of months in employment, worked more total hours and earned higher wages than those in comparison programs (Bond, 2004; Drake et al., 1999; Lucca et al., 2004; Shaheen, Williams & Dennis, 2003). There is, however, variation in employment rates of some programs, although this is often explained by lack of fidelity to the base model. Employment rates between employment case managers can also vary significantly from 75% to 25%.

Although the Supported Work and IPS models have primarily been implemented with unemployed people experiencing mental health problems or serious mental illness, many of their components, such as integrated personal and vocational support, intensive and ongoing support and an aim to make work part of the ongoing treatment suggest they would be well suited to welfare recipients facing other barriers. They have also been shown to be equally beneficial with all participants regardless of the severity of their symptoms, age or levels of education. Level of prior work experience, however, has been associated with success in gaining employment.

Transitional support model

Transitional employment programs place participants in temporary jobs often in the non-government or public sector where they are able to gain employment experience and skills, while receiving close supervision and intensive case management in a structured work environment. Participants are usually employed around 30 hours per week for 3 to 12 months. Some programs offer additional support services during and after placement and others require participants to undertake pre-employment training or other work-related activities such as literacy classes (Kirby et al., 2002; Shaheen, Williams & Dennis, 2003). The programs typically have low program staff to client ratios of around 1:25 and utilise existing support services in the community rather than providing these as part of the program. Transitional jobs are designed to act as stepping stones to unsubsidised employment and are often targeted to unemployed people that have one or more barriers to employment and have been unable to find work through regular welfare to work programs (Waller, 2002).

A review of 6 transitional programs by Kirby et al. (2002) found that they were well equipped to deal with participants’ lack of work experience, basic job and life skills and logistical barriers but struggled in addressing more severe personal and family issues. Consistent participation in the programs was found to lead to permanent unsubsidised employment for 81% to 94% of participants who complete the program, but around half of those referred did not successfully complete the program. Participants reported that taking part in the program resulted in personal, professional and financial benefits. An evaluation of a transitional jobs program in Washington targeted to hard-to-place participants found that it resulted in a net impact on employment of 33%, higher than that for
participants in all other employment programs in the state including job search, pre-employment training and workfare (Waller, 2002).

The Advancement Plus program, a transitional jobs program in Minnesota, used a three-stage approach to working with participants facing an average of 11 barriers to employment, including mental illness (35%) substance abuse, domestic violence, homelessness and physical disability. Participants were first placed in a social packaging company, then moved to worksites in the public sector. The program employed training specialists, occupational therapists, language pathologists, advancement specialists and work site supervisors. The model also involved offering extended training opportunities on site including ESL, GED (General Educational Development qualification) and professional development classes and provided three levels that participants could progress to. At the end of the study, 43% to 47% of participants had unsubsidised employment across the five sites. Amongst participant sub-groups the following rates of competitive unsubsidised employment were achieved:

- homeless 34% to 48%
- domestic violence 18% to 53%
- drug abuse 18% to 47%
- ex-offenders 27% to 43%
- learning disabilities 35% to 47%

Comparisons of transitional jobs programs to the IPS model for welfare recipients have shown superior performance of the latter (Evans & Repper, 2000), and employment rates obtained through the transitional work model are not as high as those reported for the IPS model (see above). However, these differences may be due to differences in the target populations.

There is also some concern about the displacement effects of transitional jobs programs, but this can be minimised by time-limited jobs that are separate from other work activities (EnSearch Inc., 2004). The programs are also dependent on being able to identify employers that will pledge permanent jobs (Johnson, Schweke & Hull, 1999).

Other models

**Customized Employment Supports model**

The Customized Employment Supports model was designed in New York to assist unemployed methadone patients with multiple individual barriers. It integrates elements from other models such as supported employment, intensive case management and traditional treatment principles. It uses a change mechanism for increasing self-efficacy—which is seen as critical for facilitating attitudinal and behavioural change required to enter employment—that is grounded in established psychological theory (Blankertz et al., 2004). Other key elements include using a fieldwork technique (spending time outside the office) to engage patients and a deferral system providing patients with time out when they need to focus on other issues such as health problems or substance abuse (Staines et al., 2004).

The model aims to reduce direct and indirect barriers to employment and help patients manage remaining barriers so they can move into competitive employment that matches their preferences. Four types of barriers influenced the model: poor education and employment histories; life barriers (substance abuse, homelessness, mental health problems, physical health problems, poverty etc); dysfunctional attitudes or behaviours; low self efficacy(Blankertz et al., 2004).

An evaluation after the first 6 months of an 18-month intervention model found that 66% of participants obtained paid employment (any type) during the follow-up period compared with only
41% of those receiving standard employment counselling. A smaller number had obtained ‘on the books’ competitive employment (27% compared with 14% of those receiving employment counselling) (Magura et al., 2004).

Job Training for the Homeless Demonstration Program
The Job Training for the Homeless Demonstration Program was delivered in 63 sites by nonprofit organisations in the US receiving flexible funding from the Department of Justice. It was based on an assumption that integrating vocational services with personal support services to overcome barriers would provide better employment outcomes. Sites were required to provide a range of employment services as well as other assistance such as outreach, case management, substance abuse and mental health services, housing assistance, childcare and life skills development (Shaheen, Williams & Dennis, 2003).

The program evaluation indicated that around 35% of participants were placed in employment at the end of the program and 55% were still in employment 13 weeks later. People with mental illnesses were less likely to have been in employment in the prior 6 months but achieved employment outcomes comparable to other participants (Shaheen, Williams & Dennis, 2003).

Program of Assertive Community Treatment (PACT) Model
The PACT was developed to work with people suffering from mental health problems and serious mental illness. It integrates clinical and rehabilitative services and staff can include nurses, social workers, psychiatrists, peer specialists, substance abuse counsellors and in some cases employment specialists. The PACT model has a long-term focus and provides individual assessment, placement, follow-up and reassessment. Rapid placement in work is preferred over pre-employment testing and assessments; and work is seen as an important means to address people’s strengths and limitations (Shaheen, Williams & Dennis, 2003).

Social enterprises/social firms
Social enterprises are business ventures created specifically to provide employment and opportunities for skill development for disadvantaged unemployed people who have been unable to find employment through regular employment assistance programs (Shaheen, Williams & Dennis, 2003). Like transitional employment they can provide gradually increasing responsibility in a structured work environment, and include on-site support and training. However, they do not provide consumer choice in career placement and development. They have high start-up capital requirements and carry a substantial business risk.

Conclusion
Despite a strong desire to participate in the labour market and evidence that appropriate employment is both realistic and beneficial for many unemployed people with severe personal barriers, a large proportion of this group are failing to make the transition into competitive employment.

Conventional welfare to work programs and alternative programs that either supplement work first programs with improved referrals, or move individuals outside the employment system to address personal barriers before providing vocational assistance all fail to achieve good outcomes with this client group.

Instead, research points to the need for new interventions that can provide intensive support and integrate both personal and vocational assistance. Key elements of such interventions include small case loads and intensive assistance, long-term support, rapid movement into work, using work as part of the recovery process, a strong emphasis on encouraging and supporting work and careful matching of individuals to appropriate jobs based on preferences and capabilities.
A number of models, in particular the Individual Placement and Support model used with individuals suffering from mental health disorders, show very promising results for achieving competitive employment for people facing personal barriers. However, it is still not clear to what extent these will be effective with welfare recipients with other personal barriers. It is also uncertain whether programs can support individuals with multiple barriers or should focus on supporting groups of individuals with specific barriers such as mental health, homelessness, or substance abuse.

A practical obstacle to the widespread development and adoption of such approaches is the substantial investment required by government to implement these more intensive programs, compared with the low cost high pressure work first approach. However, such investment is also likely to provide significant returns due to the high costs of long-term joblessness.
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